No. 06-923
Title: Metropolitan Life Insurance Company, et al., Petitioners
v.
Wanda Glenn
Docketed: January 5, 2007
Lower Ct: United States Court of Appeals for the Sixth Circuit
Case Nos.: (05-3918)
Decision Date: September 1, 2006
Questions Presented

~~Date~~~	~~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~~~
Nov 20 2006	Application (06A524) to extend the time to file a petition for a writ of certiorari from November 30, 2006 to January 2, 2007, submitted to Justice Stevens.
Nov 22 2006	Application (06A524) granted by Justice Stevens extending the time to file until January 2, 2007.
Jan 3 2007	Petition for a writ of certiorari filed. (Response due February 5, 2007)
Jan 22 2007	Order extending time to file response to petition to and including March 7, 2007.
Mar 7 2007	Brief of respondent Wanda Glenn in opposition filed.
Mar 20 2007	Reply of petitioners Metropolitan Life Insurance Company, et al. filed. (Distributed)
Mar 21 2007	DISTRIBUTED for Conference of April 13, 2007.
Apr 16 2007	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
Dec 21 2007	Brief amicus curiae of United States filed.
Jan 2 2008	DISTRIBUTED for Conference of January 18, 2008.
Jan 2 2008	Supplemental brief of petitioners Metropolitan Life Insurance Company, et al. filed. (Distributed)
Jan 18 2008	Petition GRANTED limited to Question 1 presented by the petition and the following Question: "If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?" The brief of petitioners is to be filed on or before Monday, February 25, 2008. The brief of respondent is to be filed on or before Monday, March 24, 2008. A reply brief, if any, is to be filed in accordance with Rule 25.3 of the Rules of this Court.
Jan 30 2008	SET FOR ARGUMENT ON Wednesday, April 23, 2008.
Feb 1 2008	Record received from U.S.C.A. for the 6th Circuit. (1 binder)
Feb 7 2008	Consent to the filing of amicus briefs in support of either party, or neither party, received from counsel for the petitioners.
Feb 11 2008	Partial record received from the U.S.D.C. for the Southern District of Ohio. (1envelope) Remainder of record is electronically filed.
Feb 25 2008	Joint appendix filed. (Statement of costs received)
Feb 25 2008	Brief of petitioners Metropolitan Life Insurance Company, et al. filed.
Mar 3 2008	Brief amici curiae of America's Health Insurance Plans, et al. filed.
Mar 3 2008	Brief amicus curiae of American Council of Life Insurers filed.
Mar 3 2008	Brief amicus curiae of Blue Cross and Blue Shield Association filed.
Mar 24 2008	Brief of respondent Wanda Glenn filed.

Mar 24 2008 Motion for leave to intervene filed by Barry Schmittou.

Mar 27 2008 Brief amicus curiae of New York City Chapter of the National Multiple Sclerosis Society filed. (Distributed)

Mar 28 2008 CIRCULATED.

Mar 28 2008 Brief amici curiae of Trust Law and ERISA Law Professors filed. (Distributed)

Mar 31 2008 Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.

Mar 31 2008 Brief amicus curiae of United States filed. (Distributed)

Mar 31 2008 Brief amici curiae of National Employment Lawyers Association, et al. filed. (Distributed)

Mar 31 2008 Brief amici curiae of South Brooklyn Legal Services and Legal Services NYC filed. (Distributed)

Mar 31 2008 Brief amicus curiae of Legal Aid Society- Employment Law Center filed. (Distributed)

Mar 31 2008 Brief amicus curiae of American Dental Association filed. (Distributed)

Mar 31 2008 Brief amicus curiae of AARP filed. (Distributed)

Mar 31 2008 Brief amici curiae of Law Professors filed. (Distributed)

Mar 31 2008 Brief amicus curiae of National Association of Insurance Commissioners filed. (Distributed)

Apr 2 2008 Motion DISTRIBUTED for Conference of April 18, 2008.

Apr 11 2008 Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.

Apr 16 2008 Reply of petitioners Metropolitan Life Insurance Company, et al. filed. (Distributed)

Apr 21 2008 Motion for leave to intervene filed by Barry Schmittou DENIED.

Apr 23 2008 Argued. For petitioners: Amy K. Posner, Long Island City, N.Y. For respondent: E. Joshua Rosenkranz, New York, N.Y.; and Nicole A. Saharsky, Assistant to the Solicitor General, Department of Justice, Washington, D.C. (for United States, as amicus curiae.)

Supreme Court, U.S.
FILED

06-923 JAN 03 2007

OFFICE OF THE CLERK

No. __-___

In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY, PETITIONERS

v.

WANDA GLENN

On Petition For A Writ Of Certiorari To The United States Court of Appeals for the Sixth Circuit

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QUESTIONS PRESENTED

1. Whether the Sixth Circuit erred in holding, in conflict with two other Circuits, that the fact that a claim administrator of an ERISA plan also funds the plan benefits, without more, constitutes a "conflict of interest" which must be weighed in a judicial review of the administrator's benefit determination under *Firestone Tire & Rubber* v. *Bruch*, 489 U.S. 101 (1989)?

2. Whether the Sixth Circuit erred in holding, in conflict with six other Circuits, that an ERISA claim administrator must consider and refute in its written disability determination a decision, without the underlying record, of a Social Security Administration administrative law judge?

PARTIES TO THE PROCEEDINGS

The parties to the proceedings at the Sixth Circuit are the Petitioner-Defendants, Metropolitan Life Insurance Company, the Long Term Disability Plan for Associates of Sears, Roebuck and Company and the Respondent-Plaintiff, Wanda Glenn. There are no other parties.

RULE 29.6 STATEMENT

Petitioner, Metropolitan Life Insurance Company, is a wholly owned subsidiary of MetLife, Inc., which is a publicly traded company. No publicly held entity owns 10% or more of MetLife's stock.

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INTRODUCTION

Petitioners, MetLife (Metropolitan Life Insurance Company) and Long Term Disability Plan for Associates of Sears, Roebuck and Company, respectfully petition for a writ of certiorari to review the September 1, 2006 decision of the United States Court of Appeals for the Sixth Circuit. That decision, following prior Sixth Circuit precedent, held that (1) the fact that a claim administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits, without more, constitutes a conflict of interest which must be weighed on judicial review of the claim administrator's benefit determination, and (2) a bare opinion by an administrative law judge of the Social Security Administration, without any of the underlying testimony or exhibits, must be considered and specifically rebutted in the determination of the ERISA claim administrator. Each of these holdings conflicts with decisions in other circuits, contravenes Congress' purposes in enacting ERISA, and otherwise merits this Court's review.

OPINION BELOW

The opinion of the United States Court of Appeals for the Sixth Circuit reversing the decision of the United States District Court for the Southern District of Ohio is reported at 461 F. 3d 660 and is reproduced in the Petitioners' Appendix. Pet. App. 1. The opinion of the District Court is not reported and is reproduced in the Appendix. Pet. App. 2. The opinion of the administrative law judge of the Social Security Administration regarding respondent's claim for Social Security disability benefits is reproduced in the Appendix. Pet. App. 3.

JURISDICTION

The judgment of the Court of Appeals was entered on September 1, 2006 and the time for filing this petition was extended by Justice Stevens to January 2, 2007. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The Employee Retirement Income Security Act of 1974, as amended ("ERISA") provides in pertinent part:

> Any employee benefit plan may provide—(1) that any person or group of persons may serve in more than one fiduciary capacity with respect to the plan (including service both as trustee and administrator).

29 U.S.C. § 1102(c)

> Nothing in section 1106 of this title shall be construed to prohibit any fiduciary from - . . .
>
> (3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

29 U.S.C. § 1108(c)

STATEMENT

On June 20, 2000, respondent Wanda Glenn applied for and received disability benefits under an ERISA-regulated plan provided by her employer, Sears Roebuck & Company. (JA 288-290[1]) MetLife approved respondent's claim for benefits under the plan's definition of disability for the first twenty-four months. Subsequently, respondent applied for Social Security disability benefits and an administrative law judge of the Social Security Administration held that she was totally disabled and entitled to Social Security benefits. (JA 322-326, 331-336) In July 2002, MetLife notified her that her benefits would be reevaluated under the plan's definition of disability applicable to claims after the first twenty-four months of benefits. (JA 170-172) Respondent submitted the Social Security administrative law judge's determination of total disability in support of her claim but failed to submit

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[1] References to the Joint Appendix to the Sixth Circuit are preceded by "JA".

the underlying medical opinions and testimony. (JA 170-172) MetLife reviewed the entire record, including the medical reports, and determined that respondent was not "completely and continuously unable to perform the duties of any gainful work." (JA 198-201) Petitioners thus terminated her long-term disability benefits.

Respondent appealed the denial of her long-term disability benefits by filing a Complaint in the United States District Court for the Southern District of Ohio pursuant to 29 U.S.C. § 1132(A). (JA 4-6) The District Court denied respondent's Motion for Judgment on the Administrative Record and granted Petitioners' Cross Motion for Judgment on the ground that Petitioners' determination was not arbitrary and capricious. (JA 104-122)

A panel of the Sixth Circuit reversed. Purporting to apply this Court's decision in *Firestone Tire & Rubber* v. *Bruch*, 489 U.S. 101 (1989), the panel first found that "we are entitled to take into account the existence of a conflict of interest that results when, as in this case, the claim administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits and to factor in the claim administrator's failure to give consideration to the Social Security Administration's determination that Glenn was totally disabled." Pet. App. 2a. The panel noted that the district court, consistent with Sixth Circuit precedent, "identified this conflict of interest as a relevant factor in determining whether an abuse of discretion had taken place." *Id.* at 10a. However, the panel faulted the district court for failing to "include any discussion of the role that MetLife's conflict of interest may have played in its decision nor appear to give that conflict any weight." *Ibid.* Accordingly, the panel found that "this factor did not receive appropriate consideration by the district court." *Ibid.*

The panel also faulted the district court (and MetLife) for failing to give what it considered appropriate weight to the

Social Security Administration's ("SSA") prior decision in respondent's favor. According to the panel: "That MetLife apparently failed to consider the Social Security Administration's finding of disability in reaching its own determination of disability does not render the decision arbitrary per se, but it is obviously a significant factor to be considered upon review." *Id.* at 15a.

The panel then reversed the District Court, holding that "MetLife's decision to deny long-term benefits in this case was not the product of a principled and deliberative reasoning process, MetLife acted under a conflict of interest and also in unacknowledged conflict with the determination of disability by the Social Security Administration." *Id.* at 24a.

REASONS FOR GRANTING THE PETITION

The Sixth Circuit's decision is the latest manifestation of a mature, deep and acknowledged conflict among the circuits on two important questions in ERISA law. The first is whether an ERISA claim administrator that also funds the plan benefits has a "conflict of interest" that must be considered on judicial review of the administrator's benefit determination under this Court's decision in *Firestone*. There the Court stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (citation omitted). Interpreting that statement, the Sixth Circuit holds, along with the Fourth, Fifth, Eighth, Ninth and Eleventh Circuits that such a possible[2] conflict

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[2] Courts have variously labeled the relationships, in which an ERISA administrator is also a funder of the plan, as a possible, a potential, an inherent, an apparent, a standard, an actual and a structural conflict of interest. The Court used the term "possible conflict" in *Firestone Tire & Rubber Co.* v. *Bruch* 489 U.S. 101, 115 (1989) and this petition follows that convention.

must be considered and weighed by the court.[3] The First and Seventh Circuits, by contrast, hold that such a possible conflict, without more, is not something that a court must weigh in determining whether the administrator's decision was arbitrary.

The second question is whether a bare decision, without the underlying testimony and exhibits, of an administrative law judge of the Social Security Administration must be specifically considered and refuted in an ERISA administrator's benefit determination. Here again the circuit courts are divided in an entrenched split of authority. The Sixth Circuit holds, along with the First and Second Circuits, that such a bare decision must be considered by the ERISA administrator. The Seventh, Eighth, Ninth, and District of Columbia Circuits hold that such a bare decision need not be considered and refuted in the ERISA administrator's determination.

Each of these questions demands this Court's resolution, and this case provides an excellent vehicle with which to do so.

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[3] This possible conflict is applied in a number of ways. Some circuits find that it changes the standard of review. *E.g. Carolina Care Plan Inc.* v *McKenzie* 467 F.3d 383, 386 (4th Cir. 2006). Other circuits find that it changes the burden of proof. E.g. *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006-7 (10th Cir. 2004). Still other circuits, as in this case, hold that it is evidence of an abuse of discretion by the ERISA administrator. E.g. *Darland* v. *Fortis Benefits Ins. Co.*, 317 F.3d 516, 527 (6th Cir. 2003), *overruled in part by Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822, 834, 123 S. Ct. 1965, 155 L.Ed.2d 1034 (2003). The question presented in this petition is not what effect a possible conflict should have but whether a possible conflict of interest should have any effect at all.

I. This Court Should Review And Reverse The Sixth Circuit's Holding That The Fact That An ERISA Claims Administrator Also Funds the Benefits, Without More, Creates a Conflict That Must Be Considered and Weighed on Judicial Review.

As noted, the Sixth Circuit holds that there is an actual conflict of interest when an insurance company both decides whether an employee is eligible for benefits and pays those benefits and that this conflict should be taken into account as a "factor in determining whether the decision was arbitrary and capricious." *Darland* v. *Fortis Benefits Ins. Co.*, 317 F.3d 516, 527 (6th Cir. 2003), *overruled in part by Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822, 834 (2003); *Calvert* v. *Firstar Finance Co.*, 409 F.3d 286, 292-3 (6th Cir 2004); *Peruzzi* v. *Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998). Following those precedents in this case, the Sixth Circuit found that it was "entitled to take into account the existence of a conflict of interest that results when as in this case, the claim administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits." Pet. App. 10a. The court thus held that this fact, standing alone, creates a conflict of interest that must be considered and weighed on judicial review.

A. The Sixth Circuit's Rule Squarely Conflicts with Decisions in Two Other Circuits.

There is a clear split among the circuits on this question. The First and Seventh Circuits hold that the fact that an administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits, without more, does not create a conflict that must be "weighed" as part of the judicial review described in *Firestone*. As the First Circuit has explained, the natural potential for a conflict of interest in that situation is countered by other market forces (employers' desires to please their employees) which offset the risk that the insurer will be "overly tight-fisted."

Wright v. *R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-5 & n. 5 (1st Cir. 2005) (recognizing and commenting on the conflict in the circuits).

Similarly, the Seventh Circuit held in *Mers* v. *Marriott International Group Accidental Death and Dismemberment Plan* 144 F.3d 1014, 1020, (7th Cir 1998), "We presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict... The existence of a potential conflict is not enough.... Mers has not established an actual conflict or a significant one. In fact, she offers no evidence that a conflict exists other than her theory of an inherent [potential] conflict. This production is not enough to show an actual bias." (Citations omitted)

The Seventh Circuit reached the same result, on similar analysis, in *Chojnacki* v. *Georgia Pacific*, 108 F.3d 810 (7th Cir. 1997). Speaking of alleged "structural conflicts" arising from claims administrators that play dual roles, the Court observed:

> "We have rejected similar claims of conflict of interest. In *Chalmers* v. *Quaker Oats Co.*, for example, an unfunded ERISA plan was administered by a committee made up of the corporation's officers. 61 F.3d 1340, 1344 (7th Cir.1995). We found no conflict of interest, noting that ERISA endorses the idea that a corporate officer can also serve as a plan administrator. We explained that in such cases the 'impact on a company's welfare of granting or denying benefits under a plan will not be sufficiently significant as to threaten the administrator's partiality.' *Id.* In support, we pointed out that Quaker Oats' annual revenue was over $6 billion, so the company was unlikely to "flinch at paying out $240,000." *Id.* Finally, we noted that companies who develop reputations for being tight-fisted when it comes to paying benefit claims

might have trouble attracting new talent and be forced to pay higher wages. *Id.*"

Thus, in all three decisions – *Mers, Choimacki and Chalmers* -- the Seventh Circuit concluded that a merely structural conflict does *not* establish the kind of "conflict of interest" that must be weighed in the judicial review contemplated by *Firestone*.

These decisions, like the First Circuit's decision in *Wright*, obviously conflict with the Sixth Circuit's holding here that the possible conflict of a claims administrator who also funds plan benefits is enough to establish "the existence of a conflict of interest" for purposes of judicial review under *Firestone*. Pet. App. 10a. If the Sixth Circuit had followed the rulings of the First and Seventh Circuits, it could not have reversed the district court's decision based on its view that petitioner's "dual roles" established a conflict of interest.

B. Six Other Circuits Also Consider An ERISA Administrator's Dual Roles As Evidence Of A Conflict of Interest

The Sixth Circuit's holding is consistent with rulings in six other circuits, thereby establishing a 2-7 circuit split on this issue. Specifically, the Third, Fourth, Fifth, Eighth, Ninth and Eleventh Circuits hold that the fact that an ERISA administrator also funds the plan, without more, creates a conflict of interest that must be considered and weighed in a judicial review. For example, the Fourth Circuit in *Carolina Care Plan Inc.* v. *McKenzie* 467 F.3d 383, 386 (4th Cir. 2006) stated that "We have consistently reduced the deference afforded to administrators based on the "mere" fact that they also insure the plan and thus profit by denying claims." Thus, these circuits hold that the "mere" fact that the funding source is also the claim administrator is sufficient to require consideration and "weighing" of a conflict of interest on judicial review under *Firestone*. *Accord Pinto v. Reliance*

Standard Life Ins. Co., 214 F.3d 377, 393 (3rd Cir. 2000); *Wildbur* v. *ARCO Chem. Co.*, 974 F.2d 631, 638-42 (5th Cir. 1992); *Woo* v. *Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998); *Abatie* v. *Alta Health & Life Ins. Co.* 458 F.3d 955, 968 (9th Cir. 2006); *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006-7 (10th Cir. 2004); *Brown* v. *Blue Cross & Blue Shield of Ala. Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990)

To be sure, these circuits disagree among themselves as to the *effect* of such a conflict on the nature and scope of judicial review (a disagreement that is not the subject of the present petition). As noted, in the Fourth Circuit, such evidence simply "reduce[s] the deference afforded to administrators." 467 F.3d at 386. In the Tenth and Eleventh Circuits, by contrast, a possible conflict of interest shifts the burden to the claim administrator to prove that its decision was not affected. *Fought* v. *UNUM Life Ins. Co. of Am* , 379 F.3d 997, 1006-7 (10th Cir. 2004) (holding that administrators acting under a possible conflict of interest have the burden of showing that their decision to deny disability benefits is supported by substantial evidence); *Brown* v. *Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990) (holding the decision of a plan administrator's with a possible conflict is presumptively void and shifting burden of proof to insurer). In the Third, Fifth and Eighth Circuits, the possible conflict triggers a sliding scale standard of review in which the possible conflict is considered as evidence of an abuse of discretion. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3rd Cir. 2000); *Wildbur* v. *ARCO Chem. Co.*, 974 F.2d 631, 638-42 (5th Cir. 1992); *Woo* v. *Deluxe Corp.*, 144 F. 3d 1157, 1161 (8th Cir. 1998). The Ninth Circuit, while rejecting the sliding scale analysis, requires the district court to consider the "inherent conflict" arising from an insurer's dual roles as a factor in determining how much deference to afford the administrator. *Abatie* v. *Alta Health & Life Ins. Co.*, 458 F.3d 955, 968 (9th Cir. 2006) ("A district court, when faced with all the facts and circumstances, must decide in

each case how much or how little to credit the plan administrator's reason for denying insurance coverage. An egregious conflict may weigh more heavily (that is, may cause the court to find an abuse of discretion more readily) than a minor, technical conflict might.")[4]

However, all of these circuits agree, contrary to the rulings of the First and Seventh Circuits discussed above, that the mere existence of these dual roles constitutes a conflict of interest that must be "weighed" when a court conducts the review required by *Firestone*. This conflict, which is ultimately a conflict over the proper interpretation of that decision, could hardly be more stark.

C. The Sixth Circuit's Holding is Incorrect.

As noted, the Sixth Circuit relied in part upon the petitioners' "dual function" to find that petitioners' disability denial was an abuse of discretion. That conclusion, however, and similar conclusions by the other six circuits that follow this approach, is incorrect for two fundamental reasons.

First, the Sixth Circuit's approach contravenes Congressional purposes in enacting the statute. Congress was aware of the widespread practice of appointing plan funders as claims administrators and nevertheless authorized employers to appoint claims administrators that are also funders of

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[4] The Second Circuit has gone both ways on this question. Compare, *e.g.*, *Pagan* v. *NYNEX Pension Plan*, 52 F.3d 438, 443 (2d Cir. 1995), with *Jordan* v. *Retirement Committee of Renssalaer Polytechnic Inst.*, 46 F.3d 1264, 1274 (2d. Cir. 1995)..

If the Court ruled that the kind of potential conflict or structural conflict at issue in this case—and present in many others—is not a "conflict of interest" for purposes of a *Firestone* analysis, many of these cases could easily be resolved solely on that basis, without a court's having to reach the issue of what *effect* the alleged conflict may have on the court's review.

the plan. Indeed, ERISA specifically provides that "[a]ny employee benefit plan may provide – (1) that any person or group of persons may serve in more than one fiduciary capacity with respect to the plan (including service both as trustee and administrator)." 29 U.S.C. § 1102(c). Congress also explicitly provided in, 29 U.S.C. § 1108(c)(3), that 29 U.S.C. § 1106 (specifying prohibited transactions) shall not be construed so as "to prohibit any fiduciary . . . from serving as a fiduciary in addition to being an officer, employee agent, or other representative of a party in interest." ERISA thus envisions that a fiduciary "may 'wear two hats,' one of a trustee or fiduciary and one of a settlor." *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1005 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005). As stated by the Court in *Pegram* v. *Herdrich*, 530 U.S. 211, 225 (2000), "...the analogy between ERISA fiduciary and common law trustee becomes problematic. This is so because the trustee at common law characteristically wears only his fiduciary hat when he takes action to affect a beneficiary, whereas the trustee under ERISA may wear different hats."

In spite of the language of ERISA, some circuits have attempted to discourage employers from appointing claims administrators that also fund the plan. As the Eleventh Circuit puts it, "one reason for limiting the deference when the fiduciary suffers a conflict of interest is to discourage arrangements where a conflict arises." *Brown* v. *Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990). In other words, even though Congress specifically permitted employers to appoint ERISA claim administrators who are also funders of the benefit plan, some courts are using treating that practice as a "conflict of interest" in an effort to discourage employers from making those appointments.

Such efforts contravene Congress' purpose. ERISA was passed not only to protect the rights of beneficiaries but also

to encourage employers to create and maintain voluntary benefit plans, *see* H. R. Rep. No. 533, 93d Cong., 2nd Sess. 1, reprinted in 1974 U.S.C.C.A.N. 4639, *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996), and "to maintain the premium costs of [the ERISA] system at a reasonable level." 29 U.S.C. § 1001b(c)(5). This Court has emphasized both "the public interest in encouraging the formation of employee benefit plans" and "the need for prompt and fair claims settlement procedures." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 54 (1987), overruled in part by *Ky. Ass'n of Health Plans, Inc.*, v. *Miller*, 538 U.S. 329 (2003). In *Varity Corp.*, 516 U.S. at 497, the Court pointed out that courts should take into account Congress's "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans." Congress permitted employers to appoint claims administrators that also fund the plan benefits to encourage employers to adopt voluntary employee benefit plan. The Sixth Circuit rule penalizes employers merely for appointing a claim administrator that also funds the benefit plan even though the law specifically authorizes that appointment.

Second, the Sixth Circuit's approach–like that in the other circuits that also consider the mere presence of "two hats" as creating a conflict—ignores economic reality. For example, the benefit requested in this case compared to the annual income of MetLife is negligible. Recognizing this, a number of courts have rejected the categorical generalization that claim administrators will act in their own self-interest in making benefit decisions. As the Seventh Circuit put it in a case involving this petitioner:

> Although MetLife acts as both a claim administrator and a funder of the plan, that factor, standing alone, does not constitute a conflict of interest. *See Chalmers* v. *Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995). Indeed, it has

> not been demonstrated that MetLife has a direct stake, in terms of its own financial health, in the outcome of this issue of interpretation. *See Cuddington* v. *Northern Ind. Pub. Serv. Co.*, 33 F.3d 813, 816 (7th Cir. 1994) (refusing to find a conflict on a similar theory absent "specific evidence showing that the [claim administrator] had a conflict of interest").

Cozzie v. *Metropolitan Life Ins. Co.*, 140 F.3d 1104, 1108 (7th Cir. 1998).

By contrast, the Sixth Circuit's holding wrongly stereotypes claim administrators by assuming that they will inevitably place their own putative short-run interest over the interest of the plan beneficiary. The assets and annual revenues of most insurance companies and employers that serve as claim administrators exceed the amount potentially awarded in a benefit claim by a huge margin. There is no legitimate reason to make a categorical assumption that a claim administrator will deny a claim to make a contribution to the company's annual profits. In fact, the company may not have any self-interest. As the Seventh Circuit noted, an insurance company that serves as a claim administrator "may not have any stake in the decision. . . . For many large firms, health and disability insurance on their labor forces is retrospectively rated. This means that the employer agrees to reimburse the insurer for all outlays, plus a loading charge and administration fee." *Perlman* v. *Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981 (7th Cir. 1999). For that reason, "[w]e have no reason to think that [the insurance company's] benefits staff is any more 'partial' against applicants than are federal judges when deciding income-tax cases." *Id.*

The Sixth Circuit was wrong to ignore these considerations in concluding that the mere fact that an ERISA administrator is statutorily permitted to "wear two hats" is enough

to establish a conflict of interest that must be weighed during judicial review of the administrator's benefit decision.

D. The Court's Resolution Of This Issue Is Vital And This Case Is An Ideal Vehicle For Resolving It.

This Court's resolution of the first question presented is vital for three reasons. First, it will enable the Court to achieve one of ERISA's "principal" goals, which is to "establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001), quoting *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987). When it enacted ERISA, Congress intended,

> [T]o ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflict directives . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

New York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645, 656-657 (1995), quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990).

Despite this Congressional purpose, the Sixth Circuit applies a conflict of interest rule directly contrary to the conflict of interest rule used by other circuit courts. "Uniformity is impossible" if different circuits subject decisions by administrators to different legal obligations. *Engelhoff*, 532 U.S. at 148. Because of the split in the circuits, an administrator of a national benefit plan may have a benefit decision accepted in the First or Seventh Circuits and have the same benefit decision under the same plan rejected by the Sixth Circuit. Only this Court can bring resolution to this issue.

Second, as acknowledged by the circuit courts, the issues are clear and well developed and the conflict is wide, exten-

sive and mature. *Wright* v. *R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (1st Cir. 2005); *Pinto* v. *Reliance Std. Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir. 2000)

Third, there cannot be any doubt that this conflict in the circuits is desperately in need of resolution. During the past two decades, hundreds of judges have labored over whether an ERISA administrator's status as a plan funder taints the administrator's benefit decision. The lower courts have expressed a desire for further guidance. As stated in *Pinto* v. *Reliance Std. Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir 2000), "courts have struggled to ... to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." Indeed, the D.C. Circuit has recently commented in *SBC Pension Benefit Plan - Non Bargained Program*, 366 U.S. App. D.C. 1, 8 (D.C. Cir. 2005), that this Court's "opaque direction about how courts should review discretionary benefits denials by potentially conflicted [plan] fiduciaries 'in ERISA cases has' bedeviled the federal courts 'ever since.'" *Firestone* was decided. (citation omitted).

Given the conflict among the circuits, the desire for further guidance, and the vast amount of time being spent on these issues by the circuit and district courts, there is no reason to let this issue remain unresolved any longer.

This case is also a compelling vehicle for resolution of the conflict. The Sixth Circuit's reasoning is clear, the relevant facts are well-developed and the issues clearly defined. Accordingly, this case provides an ideal vehicle by which the Court can choose among the various approaches and, in so doing, resolve the circuit conflict outlined above.

II. The Sixth Circuit's Holding That A Claim Administrator Must Specifically Consider In Its Determination A Bare Decision By The Social Security Administration Also Warrants Review.

The Sixth Circuit's holding that an ERISA administrator must give weight to a bare decision by an administrative law judge of the Social Security Administration independently merits this Court's review. In this case, the Sixth Circuit found that Petitioners failed to address "Social Security's contrary determination of Glenn's status." Pet. App. 12a. Yet, the only evidence before the Court or the administrator was the decision of the administrative law judge of the Social Security Administration. Pet. App. 3. Respondent did not provide the underlying testimony and exhibits of the Social Security hearing to the claim administrator.[5] Nevertheless, the Sixth Circuit overturned the ERISA administrator's benefits decision, holding that "... an ERISA plan administrator's failure to address the Social Security Administration's finding that the claimant was 'totally disabled' is yet another factor that can render the denial of further long-term disability benefits arbitrary and capricious." *Id.* at 669. In addition, the Circuit held that "MetLife obviously should have given appropriate weight to that deter-

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[5] There is no requirement that the claim administrator acquire Social Security Administration transcripts and exhibits. *Vega* v. *National Life Services*, 188 F. 3d 287, 298 (5th Cir 1999); *Donato* v. *Metropolitan Life Ins. Co.*, 19 F. 3d 375, 380 (7th Cir. 1994) (The ERISA administrator was aware of the SSA determination but did not have the underlying record. The Circuit held "...although MetLife was apprised of ...[the SSA]... determination, the Social Security file was never before MetLife in making Ms. Donato's benefits determination; and MetLife was bound only to consider what evidence and information it had before it."), *disapproved of in part by Diaz* v. *Prudential Ins. Co. of America*, 424 F. 3d 635, 638-9 (7th Cir. 2005)

mination." *Id.* at 667 This holding follows other decisions of the Sixth Circuit holding that in denying a disability claim, the ERISA administrator must specifically consider in its decision a Social Security Administration disability determination. *Darland* v. *Fortis Benefits Ins. Co.*, 317 F.3d 516, 530 (6th Cir. 2003); *Calvert* v. *Firstar Fin., Inc.*, 409 F.3d 286, 294 (6th Cir. 2005).[6]

A. The Sixth Circuit's Holding that A Bare Determination By The Social Security Administrator Of Total Disability is Evidence Which Must Be Considered by An ERISA Administrator Conflicts with Decisions in Four Other Circuits.

The Sixth Circuit's approach, however, conflicts with decisions in four other circuits. Specifically, the D.C., Seventh, Eighth, and Ninth Circuits hold that a bare decision by the Social Security Administration has *no* evidentiary weight.

For example, the D.C. Circuit in *Block* v. *Pitney Bowes, Inc.* 952 F.2d 1450, 1455-6 (D.C. Cir. 1992), refused to give any weight to a bare Social Security decision. In that case, the employee argued that the Social Security Administration's award of disability benefits to him demonstrated the arbitrariness of the ERISA administrator's final decision. But the D.C. Circuit stated that "[t]he Social Security award, however, rested at least in part on medical reports never submitted to the Committee. Courts review ERISA-plan benefit decisions on the evidence presented to the plan administrators, not on a record later made in another fo-

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[6] However, another Sixth Circuit panel in a case decided after *Darland*, but before *Calvert* and before this case, relied on *Black & Decker Disability Plan v. Nord* to conclude that the rule in *Darland* is no longer viable because it relied on the "treating physician rule." *Whitaker* v. *Hartford Life & Accident Ins. Co.*, 404 F.3d 947, 949 (6th Cir. 2005).

rum. . . . We therefore accord no weight to the Social Security Administration's determination." *Ibid.*

Similarly, in the Seventh Circuit case of *Donato* v. *Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994), an ERISA administrator was given a decision of total disability from the Social Security Administration. The administrator found that the employee was not disabled and did not address the Social Security Administration determination in his decision. The Seventh Circuit rejected the notion that courts must treat bare decisions by the Social Security Administrator as evidence in an ERISA disability determination: "[a]lthough MetLife was apprised of [the Social Security Administration's] contrary [disability] determination, the Social Security file was never before MetLife in making Ms. Donato's benefits determination, and MetLife was bound only to consider what evidence and information it had before it." *Ibid.* Thus, neither the administrator nor the reviewing court was required to give any weight to the SSA's decision.

The Eighth Circuit reached the same conclusion in *Conley* v. *Pitney-Bowes* 176 F.3d 1044, 1050 (8th Cir. 1999). There the court upheld a district court decision that an award of social security benefits "was not entitled to any particular weight in the overall consideration" of a disability claim." And the Eighth Circuit in fact gave that award no weight at all.

Similarly, the Ninth Circuit in *Madden* v. *ITT Long Term Disability Plan*, 914 F.2d 1279, 1285 (9th Cir. 1990), held that an ERISA administrator's failure to consider a determination of disability under the Social Security Administration was not arbitrary and capricious, where "all medical evidence submitted to [the plan administrator] and in the record" showed that the claimant was not "totally disabled" by standard employed in the plan. Again, the Ninth Circuit

did not require the administrator or the reviewing court to give any weight to the SSA's decision.

All of these decisions conflict with the Sixth Circuit's holding that a decision by the Social Security Administration, without more, is a fact that must be considered and weighed both by the administrator and the reviewing court. If the Sixth Circuit had followed the rulings of these other circuits, it could not have reversed the district court's decision on the basis of the administrator's failure to consider the SSA's finding of disability.

B. Two Other Circuits Hold, With The Court Below, that a Bare Determination by the Social Security Administration is Evidence Which the ERISA Administrator Must Consider in a Benefit Denial.

The Sixth Circuit's position is also supported by decisions in the First and Second Circuits, thereby creating a 4-3 split of authority on this issue. Specifically, the First and Second Circuits both squarely hold that a disability decision by the Social Security Administrator is evidence to be considered by the ERISA administrator.

For example, in *Pari-Fasano* v. *ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 420 (1st Cir. 2000), the First Circuit held that "...a Social Security benefits decision might be relevant to an insurer's eligibility determination, [although] it should not be given controlling weight..." Similarly, in *Paese* v. *Hartford Life and Accident Ins. Co.*, 449 F.3d 435, 442 (2nd Cir. 2006), the Second Circuit held that "[t]he court acted well within its discretion when it considered the SSA's findings as some evidence of total disability, even though they were not binding on the ERISA Plan, and even though the SSA's definition of disability may differ from that in the Sequa Plan."

C. The Sixth Circuit's Holding Contravenes Congressional Goals and is Otherwise Incorrect.

Like the Sixth Circuit's holding on the effect of an insurer's dual roles, the Circuit's requirement that ERISA administrators consider and refute bare disability determinations by the Social Security Administration is also wrong for several reasons.

1. First, the Sixth Circuit's approach contravenes Congress's goals in enacting ERISA. Decisions of the Social Security Administration are based upon different statutory law, administrative procedures and evidentiary rules that do not apply to ERISA administrators. That fact was recently recognized by this Court in deciding whether the Social Security Administration's treating physician rule should be transported into ERISA cases:

> The Social Security Act creates a nationwide benefits program funded by Federal Insurance Contributions Act payments ... and superintended by the Commissioner of Social Security. To cope with the "more than 2.5 million claims for disability benefits [filed] each year," ... the Commissioner has published detailed regulations governing benefits adjudications. ...Presumptions employed in the Commissioner's regulations "grow out of the need to administer a large benefits system efficiently." ...
>
> In contrast to the obligatory, nationwide Social Security program," nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." ... Rather, employers have large leeway to design disability and other welfare plans as they see fit. ...

Black & Decker v. *Nord, supra,* 538 U.S. at 833 (2003). The Sixth Circuit's approach ignores the critical differences between these two systems.

In addition, a fiduciary, such as petitioner, owes a duty not just to the participant seeking benefits, but also to the plan as a whole. *Varity Corp* v. *Howe,* 516 U.S. 489, 513 (1996); 29 U.S. C. § 1104(a)(1)(A). Plan fiduciaries thus cannot pay all claims, because if they do, premiums or contributions will have to rise - increasing costs to all participants. ERISA was passed not only to protect the rights of beneficiaries but also to encourage employers to create and maintain voluntary benefit plans, see H.R Rep. No. 553, 93rd Cong., 2nd Sess. 1 reprinted in 1974 U.S.C.C.A.N. 4639; *Varity* v. *Howe,* 516 U.S. 489, 497 (1996) and to maintain premium cost of [the ERISA] system at a reasonable level." 29 USC. § 1001b (c)(5). Here again, the approach of the Sixth Circuit and its allies ignores this critical duty that the law imposes on plan administrators.

2. The Sixth Circuit's approach also ignores, not only "the public interest in encouraging the formation of employee benefit plans," but also "the need for prompt and fair claims settlement procedures." *Pilot Life Ins. Co.* v. *Dedeaux,* 481 U.S. 41, 54 (1987). For example, in *Varity Corp.*, 516 U.S. at 497, the Court pointed out that courts should take into account Congress's "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans."

In this case the administrator was aware of but did not comment on the disability determination of the administrative law judge. While the underlying testimony and evidence may have been of some value, the bare decision of the administrative law judge is meaningless considering the differences in the laws, procedures and evidentiary rules between the ERISA and Social Security regimes. And requiring claim administrators to address and refute Social Security Administration decisions in such circumstances would introduce additional costs and delay.

This Court's decision in *Black & Decker* v. *Nord* rested, in part, on these very concerns. There the Court addressed the issue of whether the ERISA administrator must specifically consider in writing the opinion of the treating physician. The Court concluded that reviewing courts may not "impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Black & Decker* at 834. A bare determination by the Social Security Administration has less evidentiary value than a treating physician's opinion and therefore should not require specific consideration in the ERISA administrator's written opinion.

For all of these reasons, the Sixth Circuit's decision is wrong on the merits, and should be reviewed and reversed.

D. The Present Circuit Conflict is Intolerable and Should Be Resolved in This Case.

As with the first question presented, there are compelling reasons for this Court to resolve the confusion and conflict over the proper treatment of a Social Security Administration decision.

First, such a resolution will foster and protect the uniformity that is central to the entire ERISA scheme – uniformity that is currently absent because different circuits impose different standards on ERISA administrators. Indeed, at least two circuits have issued conflicting decisions as to whether petitioner MetLife, as a claims administrator for similar plans, must afford deference to the opinions of administrative law judges of the Social Security Administration. Compare *Donato* v. *Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994) (in denying disability claim, MetLife was not required to accept as evidence, or explain its rejection of, SSA decision granting disability benefits) with *Glenn*, 461 F.3d 660 (6th Cir. 2006) (in denying disability

claim, MetLife abused its discretion by not considering and refuting a SSA decision granting disability benefits).

The Sears plan at issue in this case, like many other ERISA plans, is national in scope and MetLife must administer claims on a nationwide basis. Yet here too the current split of authority on the status of Social Security Administration decisions forces administrators of national plans to use different standards based upon the circuit court that has jurisdiction. This conflicts with the ERISA mandate for uniform plan administration. *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 383-84 (2002). As this Court has put it, "Uniformity is impossible ... if plans are subject to different legal obligations in different states." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001).

Second, resolution of this question will remove an unfair and intolerable burden on ERISA administrators. As noted, the decision below requires administrators to accept or refute SSA decisions without the benefit of the underlying SSA record. The decision thereby assumes that all SSA disability cases are based on the same disability, the same definition of disability, and the same medical and vocational evidence that the claimant submitted to the ERISA claim administrator. But without the benefit of the underlying testimony and evidence presented at the SSA hearing, these assumptions may prove faulty.

Indeed, in this case, the administrative law judge did not have the benefit of the treating physician's March 13, 2002 report – in which he opined that the claimant was "able to work in a sedentary physical exertion level occupation" – because the administrative law judge's hearing on the SSA claim was held on the very same day that the report was issued. And, while the ERISA administrator was aware of the administrative law judge's decision, the administrator did not know what underlying testimony or medical records were presented in the SSA case.

Third, plenary review will enable the Court to remove the intolerable and senseless inconsistency between the treatment of SSA administrators and treating physicians. In deciding SSA disability claims, administrative law judges are required to give deference to the opinions of treating physicians. However, the Court has concluded that such deference is not required of administrators deciding ERISA based claims. *Black & Decker* v. *Nord, supra,* 538 U.S. at 833 (2003). Thus in the First, Second and Sixth Circuits, in spite of the ruling of this Court, the ERISA administrator is required to specifically refute a Social Security Administration decision based solely on a treating physician's opinion even though the administrator has no obligation to refute the treating physician's opinion itself.

The additional burdens imposed upon ERISA administrators by the decision below make it much more difficult for administrators to render consistent and streamlined claims administration throughout the United States. Under the Sixth Circuit's rule, if ERISA administrators are to make accurate and effective benefits decisions, they will have to undertake the burden of acquiring the underlying SSA record. This not only increases the time it will take to make benefits decisions, but it shifts the burden from the claimant – to provide all of the relevant evidence that supports her claim – to the ERISA administrator.[7]

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[7] This inconsistency, moreover, is not required by the pertinent regulations. ERISA and its Department of Labor ("DOL") regulations were written to provide a balance between plan flexibility and enrollee confidence in disability plans and efficiency in the disability insurance and labor markets. Yet there are no provisions in ERISA that require an ERISA administrator to accept or reject SSA decisions. ERISA regulations are written "...to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with prudent administration of the plan." (Benefit Claims Procedure Regulation, Question B-4;

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Employers do not have to provide employee disability plans. One purpose of ERISA was to encourage employers to adopt such plans. The rules imposed in this case cause inconsistent decisions from ERISA administrators and will discourage employers from establishing or maintaining long-term disability plans because of the added costs of administration and risks of reversal in court.

CONCLUSION

The petition should be granted.

Respectfully submitted

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http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg.html)
The DOL has the authority under ERISA to adopt regulations governing the administration of benefit claims for disability plans. While the DOL, as recently as 2001, issued numerous new and revised ERISA regulations, it has never required ERISA administrators to adopt, or explain their rejection of SSA decisions.

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 05-3918

WANDA GLENN,
Plaintiff-Appellant,

v.

METLIFE (Metropolitan Life Insurance Company) and LONG TERM DISABILITY PLAN for Associates of Sears, Roebuck and Company,
Defendants-Appellees.

Appeal from the United States District Court for the Southern District of Ohio at Columbus.
No. 03-00572—George C. Smith, District Judge.

Argued: April 28, 2006
Decided and Filed: September 1, 2006

Before: KEITH, MERRITT, and DAUGHTREY, *Circuit Judges*.

COUNSEL

ARGUED: Stanley L. Myers, Columbus, Ohio, for Appellant. C. Scott Lanz, MANCHESTER, BENNETT, POWERS & ULLMAN, Youngstown, Ohio, for Appellee. ON BRIEF: Stanley L. Myers, Columbus, Ohio, for Appellant. C. Scott Lanz, MANCHESTER, BENNETT, POWERS & ULLMAN, Youngstown, Ohio, for Appellee.

DAUGHTREY, J., delivered the opinion of the court, in which KEITH, J., joined. MERRITT, J. (p. 14), delivered a separate opinion concurring in the reversal of the judgment below but changing the instructions on remand.

OPINION

MARTHA CRAIG DAUGHTREY, *Circuit Judge*. The plaintiff, Wanda Glenn, filed this ERISA action against defendant Metropolitan Life Insurance Co., the plan administrator for Sears, Roebuck and Co., after MetLife terminated the long-term disability benefits that Glenn had been receiving as a former Sears employee, on the ground that her condition had improved to the point that she was no longer "totally disabled." The district court upheld MetLife's determination, finding that the decision was not arbitrary and capricious, and granted summary judgment to the defendants.

For the reasons set out below, we conclude that the record does not support the conclusion that MetLife's denial of Glenn's claim was the result of a deliberative process or that it was based on substantial evidence. We therefore reverse the judgment of the district court and remand the case for further proceedings.

FACTUAL AND PROCEDURAL BACKGROUND

The plaintiff, Wanda Glenn, worked for Sears, Roebuck from 1986 until April 29, 2000, at which point she took a medical leave of absence and has not since returned to work. Glenn's final position with Sears was as sales manager in the women's department, which entailed a workweek of 40-50 hours per week and the training and direct supervision of 20-30 sales associates. The description of her job, prepared by Sears, indicated that the job required sitting up to 20 percent of the workday, standing for 20-60 percent of the workday, and some climbing, reaching, stooping, and lifting. Glenn was responsible for supervising other employees, ensuring that her department was properly stocked with merchandise, satisfy-

ing the needs and demands of customers, and identifying and solving various problems as they arose. She reported to the store's general manager.

Glenn submitted a disability claim under Sears's long-term disability plan on June 20, 2000, attaching a letter from her treating physician, Dr. Rajendera C. Patel, dated April 30, 2000, indicating that Glenn had been diagnosed with "severe dilated cardiomyopathy," a disease of the heart muscle that causes the heart to become enlarged and, for that reason, to pump inadequately. Her symptoms included general fatigue and shortness of breath on exertion. Dr. Patel further stated, "From my standpoint, this patient cannot return to any kind of job that would require any significant physical or psychological stress."

The Sears disability plan for which Glenn applied covered two distinct stages of "total disability." The first provided that a participant was totally disabled when she was "completely and continuously unable to perform each of the material duties of [her] regular job." The second category became relevant after the first 24 months of benefits and required that the participant be "completely and continuously unable to perform the duties of *any* gainful work or service for which [she is] reasonably qualified taking into consideration [her] training, education, experience, and past earning." (Emphasis added.) Glenn's claim was approved, and she began receiving long-term disability benefits following the completion of the 140-day elimination period mandated in the plan.

Two months later, in August 2000, Glenn filed for Social Security disability benefits at the direction of plan administrators, who steered Glenn to Kennedy & Associates, a law firm specializing in obtaining such benefits. The Social Security Administration initially denied Glenn's claim, but an administrative law judge eventually issued a decision finding that Glenn was totally disabled as of April 30, 2000, and was entitled to benefits retroactive to October 2000. As a result,

MetLife demanded reimbursement for its overpayment of benefits, based on the amount of Glenn's newly awarded Social Security benefits, and collected $13,502.50 from her.

On May 20, 2003, MetLife sent a letter advising Glenn that if she wished to continue receiving long-term disability benefits, she was required to demonstrate that she met the second definition for total disability, *i.e.*, that she was "incapable of performing the material duties of any gainful occupation as defined by the plan." The letter further advised that, in making a claim determination, MetLife would review "[Glenn]'s vocational information, medical information and [Glenn]'s specific restrictions and limitations that are supported by objective medical evidence."

Glenn's medical information was provided largely by Dr. Patel, the cardiologist who oversaw Glenn's care both before and during the period relevant to this appeal. The record indicates that Glenn had developed hypertension in the early 1980s and had been treated with anti-hypertension therapy since at least 1985. In 1989, she experienced "sudden cardiac death" but was resuscitated and implanted with a defibrillator system. Diagnosed with left ventricular dysfunction, Glenn was hospitalized twice again in the 1990s, once before and once after she began work at Sears. In 2000, she began experiencing prolonged chest tightness, shortness of breath, "increasing fatigue by the end of the day," and edema in her legs from "prolonged standing at work." Because of her progressive ventricular dysfunction, at one point Dr. Patel referred Glenn to Dr. Carl Leier at Ohio State University Hospital to consider the possibility of a heart transplant. In March 2000, Dr. Patel ordered an angiogram, from which he diagnosed Glenn with severe dilated cardiomyopathy. In a letter dated April 7, 2000, Dr. Patel indicated that his patient's "main problem now is stress at work. She works in a Sears store and does have physical as well as psychological stress. Considering her low ejection fraction, I feel that she

may not be able to continue to work in any kind of environment that would cause any significant physical or psychological stress and demands." Glenn took medical leave from Sears at the end of that month.

Glenn underwent significant treatment during the next several months, taking as many as seven or eight prescription medications for her heart condition. Dr. Patel noted that, almost three months after ceasing to work at Sears, Glenn was "doing clinically well." He observed that "some of her improvement is from the reduction of stress and strain of work. She still has good and bad days and in fact there are periods where she feels extremely tired and fatigued and runs out of steam." In November 2000, however, Dr. Patel notified MetLife that Glenn was totally disabled from undertaking any occupation and that he did not expect her to be able to return to work.

In March 2001, Glenn underwent a further evaluation of her cardiomyopathy that found her ejection fraction found to be "mildly reduced" and reported "some improvement in her LV [left ventricular] function." Through a walking regime, Glenn had been able to increase her "exercise tolerance," but Dr. Patel noted that she "still gets fatigued out and short of breath, particularly if she is under any kind of significant psychologic stress." Dr Patel also reported, "From overall evaluation, Wanda seems to be clinically stable and I have advised her to continue her current regimen including Lasix, potassium, Lanoxim, Norvasc, aspirin, calcium, Normodyne and Diovan." In March 2002, a year later, when Dr. Patel filled out a MetLife long-term benefits evaluation form, he indicated that Glenn could lift and carry up to 20 pounds occasionally, had the ability to perform bilateral repetitive foot and hand movements, and could sit eight hours of the day, stand four, and walk two. He also checked "yes" when asked on the form whether she was "able to work in a sedentary physical exertion level occupation." Although the

evaluation form was intended to assess capacity for full-time work, Dr. Patel signed it without indicating whether he was releasing Glenn to return to work or what restrictions might apply if she did go back to work. In a later evaluation, Dr. Patel's answers were consistent with his earlier responses, except that he added, "No emotional stress/No heavy exertion." Dr. Patel filled out that form on June 12, 2002.

However, just six days later, Dr. Patel sent a progress report to Glenn's internist indicating that Glenn "was back in our office earlier than expected," complaining of fatigue, "shortness of breath on moderate exertion," and "significant anxiety . . . regarding the disability and having to return to work." Dr. Patel concluded, "From my standpoint, again, considering her cardiomyopathy, I do not believe she will handle any kind of stress well at her work and she would be better off being on disability" rather than returning to her job. Dr. Patel reiterated his opinion that Glenn should not return to work in a letter dated July 22, 2002:

> [Glenn] has dilated cardiomyopathy as well as a history of ventricular tachycardia requiring an implantable defibrillator device. The patient has been on multiple medications for her dilated cardiomyopathy. The patient continues to have significant difficulty with exertional shortness of breath on any kind of moderate exertion. She also continues to have significant difficulty in returning to even any kind of sedentary job because any kind of psychologic stress at work causes significant problems with her cardiovascular condition and she decompensates fast. This has happened on multiple occasions in the past. The patient has tried to return to work in the past with exacerbation of her symptoms as well as exacerbation of her condition.
>
> At the present time, I do not believe Wanda should be forced to return to any kind of even sedentary work particularly because it is the psychologic stress of work that really exacerbates her cardiovascular condition and

> symp-tomology. The patient basically should be considered completely disabled from her dilated cardiomyopathy as well as history of ventricular tachycardia.

On August 28, 2002, MetLife notified Glenn that her long-term benefits would be terminated on September 16, 2002, based on the administrative decision that "[t]here is no supportive medical documentation of the exacerbation of your cardiac condition and symptomology, due to subjective complaints of work-related stress." The notice concluded that "records submitted for review do not support cardiovascular impairment that would prevent you from performing full time sedentary work" and pointed primarily to medical information showing that Dr. Patel had found her to be "clinically stable" with "a better exercise tolerance" on November 2, 2001, and — based on a check mark on MetLife's evaluation form — able to return to work on March 13, 2002. MetLife's letter did not address Dr. Patel's letter of July 22, 2002, in which he stated that Glenn should not return to work.

Glenn appealed the denial of disability benefits. While the appeal was pending, Dr. Patel submitted a letter dated February 12, 2003, in which he reiterated his opinion that Glenn could not return to work:

> Previous reports filled out by me state that the patient was fit for sedentary work, however based on her clinical condition and her symptomology, there was never a time where I felt that this patient would be able to return to full-time employment. I strongly believe that employment would put significant stress on her overall system, and she may decompensate. Ms. Glenn does not have any emotional condition that causes her cardiac problem. She has a cardiac problem that is exacerbated by any kind of stress.
>
> My position is that she should be considered completely disabled, mainly from her cardiomyopathy and associated symptoms from her LV dysfunction.

In response, MetLife referred the case to an Independent Physician's Consultant Board. There, Dr. Chandrakant Pujara reviewed Glenn's medical records and offered an opinion based on a review of Glenn's file. In a letter dated May 2, 2003, he noted that Glenn's "ejection fraction indeed has improved with medical therapy and probably with biventricular pacing as well" but concluded that Glenn was unable to do any "exertional physical activity." Dr. Pujara's prognosis was, at best, ambiguous:

> The actual impact of any form of real or perceived emotional stress on cardiac arrhythmias, or cardiomyopathy is difficult to gauge in an individual patient. However, based on Dr. Patel's own physical capacity evaluation on June 12, 2002, the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis. If the job environment entails [a] significant degree of emotional stress, and the patient is not able to cope with that, then certainly permanent disability can be considered.

Despite the equivocal nature of this report, MetLife issued a final denial of disability benefits to Glenn on May 20, 2003. The notice of denial relied on the same information as in the prior termination notice, notably Dr. Patel's June 2002 evaluation form, as well as Dr. Pujara's assessment. Although MetLife acknowledged Dr. Patel's letter of February 2003, in which he clarified his position regarding Glenn's ability to return to work, MetLife concluded that "documentation on file does not support a disability that would prevent Ms. Glenn from performing any occupation, as defined in the plan." As before, however, no mention was made of Dr. Patel's July 2002 letter, in which he rendered essentially the same opinion as in his letter of February 12, 2003.

Having exhausted her administrative remedies under the plan, Glenn brought a civil action pursuant to Section 502(a) of the Employee Retirement Income Security Act of 1974, as

amended, 29 U.S.C. § 1132 (ERISA). The district court denied her motion for judgment on the administrative record and, instead, granted MetLife's cross-motion. This appeal followed.

DISCUSSION

A. Standard of Review

We review *de novo* the decision of a district court granting judgment in an ERISA disability benefit action based on an administrative record, *see Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 613 (6th Cir. 1998), and apply the same legal standard as did the district court. *See id.*; *Whitaker v. Hartford Life & Accident Ins. Co.*, 404 F.3d 947, 949 (6th Cir. 2005). In this case, the district court appropriately reviewed the record under the "arbitrary and capricious" standard, because the plan at issue granted the plan administrator discretionary authority to interpret the terms of the plan and to determine benefits. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111- 15 (1989); *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 168 (6th Cir. 2003). Indeed, the plaintiff conceded that review for arbitrariness was the correct standard of review here.

Under that standard, we will uphold the administrator's decision "if it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Baker v. United Mine Workers of Am. Health & Ret. Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991). Despite this deferential standard, however, our review is no mere formality. "The arbitrary-and-capricious standard . . . does not require us merely to rubber stamp the administrator's decision." *Jones v. Metro. Life Ins. Co.*, 385 F.3d 654, 661 (6th Cir. 2004) (citation omitted). Instead, we are required to review "the quality and quantity of the medical evidence and the opinions on both sides of the issues." *McDonald*, 347 F.3d at 172.

Moreover, as discussed below, we are entitled to take into account the existence of a conflict of interest that results when, as in this case, the plan administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits and to factor in the plan administrator's failure to give consideration to the Social Security Administration's determination that Glenn was totally disabled.

B. Conflict of Interest

In the instant case, MetLife is authorized both to decide whether an employee is eligible for benefits and to pay those benefits. This dual function creates an apparent conflict of interest. *See Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 527 (6th Cir. 2003), *overruled on other grounds by Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003) (holding that plan administrators do not owe special deference to the opinion of a treating physician). In discussing the applicable standard of review, the district court identified this conflict of interest as a relevant factor in determining whether an abuse of discretion had taken place. *See Glenn v. Metropolitan Life Ins. Co.*, 2005 WL 1364625 at *4 (S.D. Ohio, June 8, 2005) (citing *Firestone Tire & Rubber*, 489 U.S. at 115 ("[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'") (internal citation omitted)). However, the court's analysis of the plan administrator's basis for terminating benefits does not include any discussion of the role that MetLife's conflict of interest may have played in its decision nor appear to give that conflict any weight. It appears to us, as a result, that this factor did not receive appropriate consideration by the district court.

C. Social Security Disability Determination

There is yet another factor that the district court appears to have given inadequate consideration. The plaintiff contends

that the plan administrator was arbitrary in failing to consider the award of disability benefits that she secured from the Social Security Administration. The record reflects that MetLife notified her that payments for long-term disability were subject to a discount for amounts received from other sources and steered her to a law firm specializing in securing disability benefits from the Social Security Administration. After the firm secured an award of benefits for her based on a claim of total disability, MetLife deducted the amount of those government benefits from the disability payments that it was obliged to pay and demanded a refund from Glenn in the amount of $13,500. And, yet, in making the decision to terminate payments under the MetLife policy, the plan administrator gave no weight whatever to the Social Security Administration's determination of total disability. Hence, Glenn posits that MetLife took blatantly inconsistent positions — relying on the finding by the Social Security administrative law judge that she was totally disabled but contending that she was capable of performing sedentary work in denying her ERISA benefits.

The district court recognized this inconsistency but declined to invoke the doctrine of estoppel. Although we conclude that this ruling was technically correct, the fact that MetLife and the Social Security Administration reached contrary conclusions regarding Glenn's disability status has two ramifications for this appeal. The first stems from the fact that MetLife assisted Glenn in obtaining Social Security benefits and reaped a financial benefit of its own when that assistance was successful. The second issue relates to the fact that, in denying Glenn continuation of her long-term benefits, MetLife failed to address Social Security's contrary determination of Glenn's status. It is obvious that both factors are relevant in determining whether MetLife's decision was arbitrary and capricious.

The courts have recognized that a disability determination by the Social Security Administration is relevant in an action to determine the arbitrariness of a decision to terminate benefits under an ERISA plan. In *Ladd v. ITT Corp.*, 148 F.3d 753, 755-56 (7th Cir. 1998), for example, the Seventh Circuit overturned a plan administrator's denial of disability benefits after finding that the insurance company had encouraged and assisted the plaintiff in applying for Social Security benefits, which were granted after an administrative law judge found that the plaintiff was totally disabled. Writing for the court, Judge Posner noted that the concept of judicial estoppel was not technically applicable but, nevertheless, he concluded that the inconsistency in litigation positions had to be factored into a review of the plan administrator's determination for arbitrariness:

> The grant of social security disability benefits . . . brings the case within the penumbra of the doctrine of judicial estoppel — that if a party wins a suit on one ground, it can't turn around and in further litigation with the same opponent repudiate the ground in order to win a further victory. The doctrine is technically not applicable here, because MetLife and ITT, the defendants in this suit, were not parties to the proceeding before the Social Security Administration. Yet they "prevailed" there in a practical sense because the grant of social security benefits to Ladd reduced the amount of her claim against the employee welfare plan. If we reflect on the purpose of the doctrine, which is to reduce fraud in the legal process by forcing a modicum of consistency on a repeating litigant, we see that its spirit is applicable here. To lighten the cost to the employee welfare plan of Ladd's disability, the defendants encouraged and supported her effort to demonstrate total disability to the Social Security Administration, going so far as to provide her with legal representation. To further lighten that cost, it then turned around and denied that Ladd was totally disabled,

> even though her condition had meanwhile deteriorated. In effect, having won once the defendants repudiated the basis of their first victory in order to win a second victory. This sequence casts additional doubt on the adequacy of their evaluation of Ladd's claim, even if it does not provide an independent basis for rejecting that evaluation.

Id. at 756 (citations omitted).

We adopted the Seventh Circuit's "penumbra" rationale in *Darland v. Fortis Benefits Insurance Co.*, a case in which the ERISA plan administrator had, as here, "requested that Darland apply for Social Security disability benefits so as to reduce the amount of monthly disability payments that it paid Darland under the plan" and then demanded reimbursement for overpayment of insurance benefits at the same time it sought to terminate Darland's benefits on the ground that he was no longer disabled. *Darland*, 317 F.3d at 530. We concluded that "a plan administrator's decision denying disability benefits where the Social Security Administration has determined that the applicant was totally disabled" can be considered arbitrary and capricious, *id.* at 529, especially where "it is plainly evident that the Social Security standard for a disability determination is much more stringent than that required by [the defendant's] insurance policy." *Id.* at 530. The latter observation not only pertains in this case to the language of the policy[1] but is all the more relevant in the

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[1] After 24 months, the plan awards disability benefits to an individual who is "completely and continuously unable to perform the duties of any gainful work or service for which he is reasonably qualified, taking into consideration his training, education, experience, and past earning." Social Security disability insurance benefits are awarded only if the individual's impairment is of such severity that he "cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives." 42 U.S.C. § 423(d)(2)(A). The Social Security determination does not take into

wake of the Supreme Court's subsequent ruling that the special deference extended to the opinion of a treating physician in a Social Security dispute is not applicable in ERISA cases. *See Black & Decker Disability Plan*, 538 U.S. at 833-34.

The district court in this case recognized that MetLife had encouraged and assisted Wanda Glenn in obtaining Social Security disability benefits, just as MetLife had in *Ladd*, but found Glenn's case to be distinguishable in two respects. First, the district court noted, correctly, that the record before the administrative law judge did not include the report, signed on the same day that the administrative judge's decision was made, in which Dr. Patel answered "yes" to MetLife's question, "Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?" However, the relative significance of this omission in the record is undercut by the existence of Dr. Patel's subsequent clarification of July 22, 2002, in which he indicated that he had never considered his patient capable of resuming full-time work, and by the fact that there is no indication in the record that Glenn's government benefits have ever been discontinued. Second, the district court found, incorrectly, that it was unclear whether or not MetLife had actually benefitted from the plaintiff's receipt of Social Security benefits. We find it abundantly clear on the record that Glenn reimbursed MetLife for overpayment of benefits, based on her receipt of Social Security benefits.

Having benefitted financially from the government's determination that Glenn was totally disabled, MetLife obviously should have given appropriate weight to that determination. As we held in *Calvert v. Firstar Finance, Inc.*, 409 F.3d 286, 295 (6th Cir. 2005), a case with several parallels to this one, an ERISA plan administrator's failure to address the Social

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account past earning or location of the applicant.

Security Administration's finding that the claimant was "totally disabled" is yet another factor that can render the denial of further long-term disability benefits arbitrary and capricious. In *Calvert*, as here, the plan administrator relied almost exclusively on the recommendation of a physician, hired by the administrator, who conducted a file review but not a physical examination of the claimant. *See id.* We held that such a review was clearly inadequate, given that in reaching the determination to deny benefits, the plan administrator not only overlooked surgical reports, X-rays, and CT scans that documented the claimant's disability, but also failed to mention the Social Security Administration's determination, "not . . . even to discount or disagree with it, which indicates that he may not even have been aware of it." *Id.* at 296.

Here, there is no possibility that the plan administrator failed to discuss the Social Security award for lack of awareness. And, "the S[ocial] S[ecurity] A[dministration] determination, though certainly not binding, is far from meaningless." *Id.* at 294. That MetLife apparently failed to consider the Social Security Administration's finding of disability in reaching its own determination of disability does not render the decision arbitrary *per se*, but it is obviously a significant factor to be considered upon review.

D. The Medical Evidence

Even more perplexing than the plan administrator's failure to consider the award of Social Security benefits is the persistent failure to give any weight to Dr. Patel's letters of July 22, 2002, and February 12, 2003, in which he clearly stated that he did not believe Glenn was capable of returning to work, sedentary or otherwise. This omission stands in stark contrast to the heavy reliance MetLife placed in its brief on the "physical capacity assessment" form that MetLife provided to Dr. Patel and that he filled in and signed on March 13, 2002. On the form, Dr. Patel indicated that his patient could sit for eight hours a day, stand for four hours, and walk

for two hours. He also checked yes when asked, "Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?" That information is so inconsistent with other medical evidence and detailed reports supplied by Dr. Patel over a period of three years that it can best be described as aberrational.

Nevertheless, MetLife cannot be faulted for its initial reliance on the opinion that Glenn could "work at a sedentary physical exertion level occupation" in consulting a "transferable skills analyst," who then compiled a list of clerical jobs (account information clerk, attendance clerk, classified ad clerk) that would be available to someone with the physical limitations listed on the physical assessment form. There is no indication in the record, however, that the transferable skills analyst considered the medical evidence in the record or Dr. Patel's reasons for concluding that his patient should not return to full-time work of any kind. Nevertheless, the plan administrator, relying only on the vocational assessment, the information on the MetLife form supplied by Dr. Patel on March 13, 2002, and certain other technical information that seems to have been almost randomly selected from his reports (one paragraph reads in its entirety, without further explanation: "Your June 18, 2002 examination showed an ejection fraction of 35 to 40%."), declined to grant further long-term benefits in a letter dated August 28, 2002. Nowhere in the notice of denial does the plan administrator mention the decision of the Social Security Administration finding that Glenn was totally disabled.

Perhaps most curious is the plan administrator's treatment of Dr. Patel's then-most recent assessments of his patient's condition. The plan administrator emphasized the content of yet another "physical capacities evaluation" dated June 12, 2002, that indicated by check-off information consistent with that on the March 13 form ("sit for eight hours, stand for four hours, walk for 2 to 4 hours," etc.). But the June 12 form does

not recommend that Glenn return to work, nor does it release her to return to work. Furthermore, the notice from the plan administrator made no mention whatever of the letter Dr. Patel sent on July 22, 2002, which, as described above, noted that Glenn "continues to have significant difficulty with exertional shortness of breath on any kind of moderate exertion" and "significant difficulty in returning to even any kind of sedentary job because any kind of psychologic stress at work causes significant problems with her cardiovascular condition and she decompensates fast." Dr. Patel concluded:

> At the present time, I do not believe Wanda should be forced to return to any kind of even sedentary work particularly because it is the psychologic stress of work that really exacerbates her cardiovascular condition and symptomatololgy. The patient basically should be considered completely disabled from her dilated cardiomyopathy as well as history of ventricular tachycardia.

This letter to MetLife is consistent with a follow-up report a month earlier that Dr. Patel sent to Glenn's internist, Dr. Rhee, in which he concluded: "From my standpoint, again, considering her cardiomyopathy, I do not believe she will handle any kind of stress well at her work and she would be better off being on disability."

Based on Dr. Patel's assessment of her condition, Glenn appealed MetLife's decision to terminate her benefits, and the decision was reviewed internally by MetLife. In a letter dated May 20, 2003, the plan administrator once again denied benefits, this time based on the evaluation form signed by Dr. Patel in June 2002, the transferable skills analysis from July 2002, and two items that had not been part of the earlier review: a letter from Dr. Patel dated February 12, 2003, and the report from the outside consultant, Dr. Pujara, dated May 2, 2003. Once again, there is no mention of Dr. Patel's July 2002 letter stating unequivocally that his patient was not able to return to work.

The appeal decision does indicate that Dr. Patel's letter "noted that his previous reports indicated that Ms Glenn was fit for sedentary work" but that "based on her clinical condition and symptomatology, Dr. Patel never felt that Ms. Glenn could return to full-time employment" and that she "should be considered completely disabled from her cardiomyopathy and associated symptoms from her LV dysfunction." On the other hand, there is no explanation in the notice for the failure to give any weight to this report.

The summary of Dr. Pujara's report reiterated the information that he found in the medical files submitted by MetLife — Dr. Pujara did not conduct an examination of Glenn but merely undertook a file review — and concluded: "The consultant noted that based on the medical information Ms. Glenn has achieved a relatively stable cardiac status." What the summary omits is any indication that the consultant thought that she could return to work. In fact, Dr. Pujara noted that given the information in her file, "the patient certainly is not able to do any exertional physical activity" and, with regard to the possibility of "sedentary activity," concluded that "[i]f the job environment entails a significant degree of emotional stress, and the patient is not able to cope with that, then certainly permanent disability can be considered." Although it appears that MetLife forwarded the June 2002 evaluation form to Dr. Pujara, there is no indication that he was provided with copies of Dr. Patel's letters of July 2002 and February 2003, in which Dr. Patel concluded that Glenn was not able to undertake sedentary work because any degree of stress caused her medical condition to "decompensate."[2]

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[2] At oral argument of this case, the defendants conceded that Glenn had not been offered a part-time position at Sears and that she would have no chance of receiving benefits under the Sears ERISA plan if she went to work at for another employer on the trial basis that Dr. Pujara suggested.

The Plan provides that "[w]hile a claim is pending, we, at our expense, have the right to have you examined by doctors of our choice when and as often as we reasonably choose." MetLife instead opted to have a file review, a decision that does not render its denial of benefits arbitrary *per se*. However, it is yet another factor to be considered in the overall assessment of its decision-making process. *See Calvert*, 409 F.3d at 295. Moreover, as noted above, it appears that the physician charged with conducting the independent file review was not provided with Dr. Patel's letters of July 2002 and February 2003.

As a result, Dr. Patel is the only physician to have personally treated and observed Glenn over the entire course of her dispute with MetLife. As noted above, the plan administrator need not accord special deference to the opinion of a treating physician. By the same token, it may not arbitrarily repudiate or refuse to consider the opinions of a treating physician. *See Black & Decker Disability Plan*, 538 U.S. at 834. In its final rejection of Glenn's claim, however, MetLife did not indicate that it had considered Dr. Patel's letter of February 12, 2003, nor did it provide a reason for rejecting it.[3] It also did not indicate whether or not it had considered Dr. Patel's letter of July 22, 2002, which was consistent with the February 12 letter advising that Glenn could not return to work.

In the absence of an explanation from MetLife, the district court provided its own, noting that because Dr. Patel "expressly acknowledged that he had stated that plaintiff was fit for sedentary work . . . MetLife did not abuse its discretion by viewing Dr. Patel's recantation with skepticism." In support of this conclusion, the district court invoked *United States v. Willis*, 257 F.3d 636, 645-46 (6th Cir. 2001), for the proposi-

[3] MetLife maintains in its brief on appeal that the denial notice "specifically discussed" Dr. Patel's letter of February 12, 2003, we find that the word "discussed" is somewhat misleading; "mentioned" would be a more accurate choice.

tion that affidavits recanting trial testimony are viewed with "extreme suspicion." The court's reliance on *Willis* is misplaced, however, because that case addresses the full recantation of a witness's testimony in a criminal trial, a situation which is hardly equivalent to Dr. Patel's follow-up letters, which were consistent with his earlier assessments of Glenn's ability to work and which are more aptly described as clarifications, rather than recantations. Indeed, the concept of recantation has little application outside the unique context of the criminal case, and any presumption regarding the credibility of inconsistent testimony should be limited to that context.

We conclude that the only fair inference from the record would actually undercut Dr. Patel's check-offs and his brief assessment on the functional capacity form dated March 13, 2002, because that information was in direct conflict both with his earlier assessments and with every detailed written explanation that he gave concerning Glenn's disability.[4] Clearly, the plan administrator rejected Dr. Patel's more detailed reports while crediting the check-off forms. However, MetLife offered no explanation for its resolution of the conflict or, for that matter, whether it was given any consideration at all. The omission is critical, because the failure to consider evidence that is offered after an initial denial of benefits renders a final denial of benefits arbitrary and

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[4] This case is not the first in which we have been called upon to review MetLife's over-reliance on an aberrational report from a physician. In *Spangler v. Lockheed Martin Energy Systems, Inc.*, a case with several interesting parallels to this one, the plan administrator denied benefits based on the responses of the plaintiff's treating physician on the same form that Dr. Patel filled out in this case, a physical capacities evaluation that we described as "somewhat aberrant," given that "all of [the physician's] prior reports and statements clearly indicate[d] that Spangler [was] not able to perform any work." 313 F.3d 356, 362 (6th Cir. 2002). We concluded that "MetLife, as Spangler contends, 'cherry-picked' her file in hopes of obtaining a favorable report from the vocational consultant as to Spangler's ability to work." *Id*

capricious. *See Williams v. Intl Paper Co.*, 227 F.3d 706, 712-14 (6th Cir. 2000). As for the district court's attempt to reconcile the conflicts in the record, we point out that the court's role is to review the basis for the decision that was actually made by the plan administrator, not to provide an adequate basis where none was offered.

The importance of a resolution of the apparent conflict between Dr. Patel's responses on the check-off form and his later reports is even more pronounced given that Dr. Patel consistently deemed psychological stress to be a critical factor in Glenn's treatment and the deciding factor in assessing her ability to return to work. On April 7, 2000, Dr. Patel wrote that Glenn's "main problem now is stress at work." On April 30, 2000, he concluded that Glenn "cannot return to any kind of job that would require any significant physical or psychological stress." On July 29, 2000, after Glenn had been on leave from work for approximately three months, Dr. Patel observed that "some of her improvement is from the reduction of stress and strain of work." On June 12, 2002, Dr. Patel also indicated that Glenn's functional limits included "no emotional stress." The law firm retained by MetLife to represent Glenn before the Social Security Administration certainly relied on Dr. Patel's analysis of the impact of stress on Glenn's condition, even if MetLife did not. Contending before the administrative law judge assigned to her claim that "[i]n addition to findings of impaired myocardial function, Dr. Patel indicated that the severity of Ms. Glenn's symptoms and physical condition were aggravated by emotional stress," the firm pointed out that "this opinion was rendered by a longtime treating source who had referred the claimant for implantation of a new cardiac device, referred the claimant for transplantation assessment, and provided consistent care while the claimant's left ventricular functioning deteriorated."

Despite the consistent and repeated references by Dr. Patel to stress as a factor in Glenn's condition, MetLife concluded

in its final denial of benefits to Glenn, "There is no supportive medical documentation of the exacerbation of your cardiac condition and symptomology, due to the subjective complaints of work-related stress." But, this conclusion unjustifiably implies that Dr. Patel's observations and notations regarding stress do not constitute "supportive medical documentation." Although it is not clear from the record what sort of documentation MetLife would have found sufficient to establish the negative effect of stress on Glenn's medical condition, the plan itself does not restrict the type of evidence that may be used to demonstrate total disability. Rather, the plan provides that "[t]o qualify for benefits under the Plan, Total Disability must be supported by current medical documentation" and the claimant "must be under the regular care of a qualified physician under a course of treatment appropriate for the disability." We conclude that the plan administrator's rejection of Dr. Patel's assessment, under the standard set out in the plan, was, in fact, arbitrary.

That conclusion is supported by our decisions in similar ERISA cases. In *Evans v. UnumProvident Corp.*, 434 F.3d 866 (6th Cir. 2006), for example, a claimant applied for long-term disability benefits on the basis that her frequent seizures rendered her incapable of work. Her treating physician opined that the stress associated with her administrative duties was responsible for the severity and frequency of the episodes. *See id.* at 870. While on medical leave, the claimant saw an improvement in her condition. Her treating physician determined that it would be in the claimant's best interest not to return to work. *See id.* at 871. The insurer denied the claim, finding it unreasonable to speculate that a return to work would exacerbate the claimant's condition. *See id.* In reaching this decision, the insurer relied heavily on an independent physician's review, which declared that the impact of stress on the patient's condition was entirely self-reported and had not been corroborated by medical studies. *See id.* at 875. We found that the insurer's decision was arbitrary and capricious.

"[D]espite the unwavering expert medical opinion of plaintiff's treating physician . . . that stress is probably the most important seizure-provoking factor in all patients, and not just plaintiff, and that plaintiff's high-stress position would exacerbate her condition, defendant nonetheless unreasonably discounted stress as merely a 'prophylactic' factor that should be accorded minimal, if any, weight in its determination of disability." *Id.* at 879.

In the present case, although Dr. Patel's opinion of Glenn's ability to perform sedentary work has not been consistently expressed, he likewise has been "unwavering" in his opinion that stress is an important factor in her condition. As in Evans, the plan in this case does not say that prophylactic determinations are not relevant to the decision, nor does it say that self-reported or "subjective" factors should be accorded less significance than other indicators. And, although it is not clear that stress is *the* most important factor in all cases of cardiomyopathy, as it apparently is with epilepsy, it is unreasonable for MetLife to have dismissed stress as an improperly documented, subjective, and irrelevant factor in its disability determination.

MetLife cites *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003), as justification for discrediting Dr. Patel's opinion that Glenn was not capable even of sedentary employment. In reviewing a benefits determination in a black lung case, the *Eastover Mining* court observed that "treating physicians may have strong pro-claimant biases and lack the expertise held by non-treating doctors." *Id.* at 510 (citing *Black & Decker Disability Plan*, 538 U.S. at 832). It is true that treating physicians, "in a close case, may favor a finding of 'disabled'," 538 U.S. at 832, and that a presumption of deference to treating physicians makes little sense when "the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks." *Id.*

Moreover, although *Black & Decker Disability Plan* makes clear that MetLife bears no heightened burden of explanation when making a disability determination that runs contrary to a treating physician's opinion, *see* 538 U.S. at 831, MetLife's decision with respect to Glenn's claim does not appear to be the result of a principled reasoning process, given that Dr. Patel had expertise in treating Glenn's disability and had a longterm relationship with her.

Finally, we note that a claimant's potential ability to "return to work under certain limited circumstances," *McDonald*, 347 F.3d at 170, should not be taken to satisfy the requirements of the Sears ERISA plan when those circumstances are, as here, very limited and would not permit Wanda Glenn, pursuant to the language of the plan, to perform the duties of gainful work for which she is reasonably qualified, "taking into consideration her training, education, experience, and past earning." As we observed in *McDonald*:

> The mere possibility that a participant in an ERISA plan might be able to return to some type of gainful employment, in light of overwhelming evidence to the contrary, is an insufficient basis upon which to support a plan administrator's decision to deny that participant's claim for [long-term disability] benefits.

Id. at 170-71.

CONCLUSION

Even when it is reviewed under the highly deferential standard applicable in this case, we conclude that the plan administrator's determination to deny benefits to Glenn cannot be sustained.

> [The] obligation under ERISA to review the administrative record in order to determine whether the plan administrator acted arbitrarily and capriciously in making ERISA benefits determinations . . . inherently includes

> some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan [administrator] was able to find a single piece of evidence — no matter how obscure or untrustworthy — to support a denial of a claim for ERISA benefits.

McDonald, 347 F.3d at 172.

For the reasons set out above, we conclude that MetLife's decision to deny long-term benefits in this case was not the product of a principled and deliberative reasoning process. MetLife acted under a conflict of interest and also in unacknowledged conflict with the determination of disability by the Social Security Administration. In denying benefits, it offered no explanation for crediting a brief form filled out by Dr. Patel while overlooking his detailed reports. This inappropriately selective consideration of Glenn's medical record was compounded by the fact that the occupational skills analyst and the independent medical consultant were apparently not provided with full information from Dr. Patel on which to base their conclusions. Moreover, there was no adequate basis for the plan administrator's decision not to factor in one of the major considerations in Glenn's pathology, that of the role that stress played in aggravating her condition and, in the language of the MetLife policy, in preventing her return to "gainful work or service for which [she is] reasonably qualified taking into consideration [her] training, education, experience, and past earning." Taken together, these factors reflect a decision by MetLife that can only be described as arbitrary and capricious.

We therefore REVERSE the judgment of the district court and REMAND the case with directions to reinstate Glenn's long-term disability benefits, retroactive to the date on which

they were terminated,[5] and for such other relief as the district court finds appropriate in view of our ruling in this case.

CONCURRENCE

MERRITT, *Circuit Judge*, concurring in the reversal of the judgment below but changing the instructions on remand. A doctor reviewing Glenn's medical records on behalf of MetLife noted that Glenn "seems to be a reasonable candidate to try one of the sedentary job classes [previously suggested by MetLife] at least on a trial basis." The contract for long-term benefits expressly provides for an arrangement called "rehabilitative employment" allowing individuals like Glenn to work on a trial basis without forfeiting their benefits. At this late point, it is unclear whether rehabilitative employment is still available under the terms of the plan. What is clear, however, is that the parties should have pursued this reasonable approach earlier. Doing so would have enabled Glenn to return to work so long as her health permitted and would have reduced MetLife's payments to Glenn. I would remand the case to the district court for a hearing in which the rehabilitative employment option is explored. Otherwise, I concur in the majority opinion.

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[5] *See Kalish v. Liberty Mutual / Liberty Life Assurance Co.*, 419 F.3d 501 (6th Cir. 2005) (remanding for retroactive reinstatement of benefits where plan administrator arbitrarily and capriciously refused to consider evidence of claimant's depression as factor in disability); *Williams v. Intl Paper Co.*, 227 F.3d 706 (6th Cir. 2000) (remanding for retroactive reinstatement of benefits where plan administrator had opportunity to review all evidence and did so in a manner that was arbitrary and capricious).

APPENDIX B

UNITED STATES DISTRIICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

[Filed June 8, 2005]

Case No. 2:2003cv0572

WANDA GLENN,

Plaintiff,

v.

METROPOLITAN LIFE INSURANCE COMPANY, *et al.*,

Defendants.

JUDGE SMITH
Magistrate Judge Abel

OPINION AND ORDER

Plaintiff seeks, *inter alia*, reinstatement of long term disability ("LTD") benefits under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1132 ("ERISA"). Both sides move for entry of judgment on the administrative record (Doc. 9 and Doc. 10). For the reasons that follow, the Court orders the entry of judgment in favor of defendants and against plaintiff.

I. Facts

Plaintiff is an individual citizen of the State of Ohio. She is a participant in the subject Sears, Roebuck and Co. ("Sears") Group Long-Term Disability Plan ("Plan"). Defendant Metropolitan Life Insurance Company ("MetLife") is the

Plan fiduciary, and makes decisions regarding claims for Plan benefits. MetLife both reviews and pays claims for benefits under the Plan. Sears is the Plan sponsor and administrator.

The Plan contains two definitions for the term "totally disabled." The first applies to the initial determination of disability, and provides that a participant is totally disabled when she is "completely and continuously unable to perform each of the material duties of [her] regular job." AR 14. The second definition becomes applicable after the first twenty-four months of benefit payments, and additionally requires that the participant be "completely and continuously unable to perform the duties of *any* gainful work or service for which [she is] reasonably qualified taking into consideration [her] training, education, experience, and past earnings." *Id.* (emphasis added).

Plaintiff worked for Sears as a sales manager in the women's department from 1994 until she became disabled. AR 153. Plaintiff was responsible for supervising other employees, ensuring that her department was properly stocked with merchandise, satisfying the needs and demands of customers, and problem identification and solution. AR 174-176. Plaintiff's responsibilities included direct supervision of twenty to thirty sales associates. AR 170.

Plaintiff worked forty to fifty hours per week before she became disabled. *Id.* Plaintiff s job at Sears required sitting 1-19% of the workday, standing 20-60% of the workday, and walking 61-100% of the workday. Her job also included some climbing, reaching, stooping, and lifting. *Id.*

Plaintiff stopped working on April 30, 2000 due to cardiomyopathy.[1] AR 128, 149. Her doctor, Raj. C. Patel, M.D., described plaintiff's symptoms as general fatigue and shortness of breath on exertion. AR. 128. Plaintiff's cardio-

[1] Cardiomyopathy is a condition causing weakness in the heart muscle.

myopathy was related to her job as sales manager for Sears. AR 153. Plaintiff also suffered from cardiac arrhythmias, and required the use of an implanted cardiac defibrillator ("ICD"). AR 96, 121. Plaintiff submitted her disability claim on June 20, 2000. AR 156. MetLife approved her claim, and plaintiff began receiving long term disability benefits in September 2000 after completing the 140-day elimination period.

On August 11, 2000, plaintiff filed for social security disability benefits ("SSDB"). AR 195. Following a hearing on her claim held March 13, 2002, an administrative law judge issued a decision finding claimant was disabled effective April 30, 2000 (AR 195), and entitled to SSDB beginning October 2000. AR 186.

In addition to use of the ICD, plaintiff's cardiomyopathy was treated with medications. During the two years plaintiff received LTD benefits, plaintiff's medical condition improved with treatment. In December 2000, plaintiff was described by her doctor as "clinically well" (AR 121) and in November 2001 as "stable." AR 110. In March 2000, when she became disabled, her "ejection fraction" was at 25%.[2] AR 129. By April 2001, her ejection fraction had improved to 40-50%, which is where it had been prior to going on disability. AR 115, 129.

In March 2002, MetLife sent Dr. Patel a letter asking him about plaintiff's ability to return to work. AR 105. At MetLife's request, Dr. Patel completed a physical capacity evaluation in which he indicated that, in an eight-hour workday, plaintiff could sit eight hours, stand four hours, and walk two hours. *Id.* Dr. Patel was also specifically asked whether

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[2] An ejection fraction is the percentage of blood pumped out of the heart chamber during each heartbeat. Typically, the left ventricle pumps 55-75% of the blood within that chamber out to the body with each heartbeat. An ejection fraction below 40% indicates heart failure or cardiomyopathy.

plaintiff was able to work fulltime at a sedentary physical exertion level occupation, and he checked "yes." *Id.*

Three months later, Dr. Patel completed another physical capacity evaluation. AR 99. At that time, he indicated that, in an eight-hour workday, plaintiff could sit eight hours, stand four hours, and walk two to four hours. *Id.* He also indicated that plaintiff could lift and carry up to ten pounds occasionally, and engage in other activities. *Id.*

MetLife reviewed plaintiff's claim in July 2002 to determine her continued eligibility for benefits. MetLife had her file reviewed by Dr. Mark Moyer, an independent physician consultant who is board certified in internal medicine. Dr. Moyer concurred with Dr. Patel that plaintiff could perform sedentary work. AR 39. Plaintiff's file was then referred to a vocational rehabilitation coordinator for a transferable skills and labor market analysis ("TSA"). *Id.* Taking into consideration plaintiff's education, background, training, and physical capacity, the vocational coordinator concluded that there were alternative sedentary occupations available in plaintiff's geographic area that plaintiff would be able to perform. AR 151-2. These alternative occupations included account information clerk, attendance clerk, and classified ad clerk. *Id.*

Plaintiff's LTD benefits were paid through September 16, 2002, which was the twenty four months after she received her first LTD benefit payment. AR 53. To be eligible for benefits after twenty four months, plaintiff not only had to be disabled from performing her own job, but also from performing any other occupation for which she was reasonably qualified. AR 14. Based on Dr. Patel's opinion that plaintiff could perform sedentary work, and based further on the results of the vocational TSA, MetLife concluded that plaintiff could perform alternate sedentary occupations, and plaintiff was advised in a letter dated July 15, 2002 that her last day of benefits would be September 16, 2002. AR 41, 72.

By letter dated July 26, 2002, plaintiff requested that MetLife reconsider its decision to terminate her benefits. AR 72. In a letter dated July 22, 2002, Dr. Patel stated that plaintiff "continues to have significant difficulty in returning to even any kind of sedentary job because any kind of psychological stress at work causes significant problems with her cardiovascular condition . . ." AR 91. Dr. Patel further stated in this same letter "the patient has tried to return to work in the past with exacerbation of her symptoms as well as . . . her condition." *Id.* Dr. Patel concluded that plaintiff "should not be forced to return to . . . even sedentary work . . ." *Id.*

MetLife then re-evaluated plaintiff's claim and concluded that benefits were not payable after September 16, 2002. Plaintiff was advised of this decision in a four-page letter dated August 28, 2002. AR 66-69. In this letter, MetLife noted that Dr. Patel previously found that plaintiff was able to work; that plaintiff's medical records supported the conclusion that plaintiff's condition was stable and plaintiff was able to perform fulltime sedentary work; and that the TSA performed by MetLife's vocational rehabilitation coordinator found alternative job positions available in the geographic area that met plaintiff's education, training, and medical capabilities. AR 67-8. MetLife informed plaintiff that she had the right to submit a written request to appeal the decision terminating her LTD benefits. AR 69.

On February 12, 2003, plaintiff, through counsel, appealed the termination of her disability benefits. AR 59. In support of her appeal, plaintiff submitted a new medical report from Dr. Patel, dated February 12, 2003, in which Dr. Patel stated:

> Previous reports filled out by me state that the patient was fit for sedentary work, however based on her clinical condition and her symptomatology, there was never a time where I felt that this patient would be able to return to full-time employment.

AR 90.

Metlife referred plaintiff's medical records to Chandrakant Pujara, M.D., F.A.C.C., an independent physician consultant board certified in cardiology. In a report dated May 2, 2003, Dr. Pujara found "with the appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status." AR 86. Dr. Pujara stated that plaintiff "has been relatively free of any significant cardiac compensation as documented by Dr. Patel's follow up notes." AR 85. Dr. Pujara then concluded that plaintiff was "capable of sedentary activity as per the U.S. Department of Labor Guidelines." *Id.* Dr. Pujara further opined:

> However, based on Dr. Patel's own physical capacity evaluation on June 12, 2002, the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis. If the job environment entails [a] significant degree of emotional distress, and the patient is not able to cope with that, then certainly permanent disability can be considered.

AR 86.

After it received Dr. Pujara's report, MetLife affirmed its earlier decision to terminate plaintiff's benefits effective September 16, 2002. MetLife concluded:

> We have determined that the documentation currently in the file does not support a disability that would prevent Ms. Glenn from performing any occupation, as defined in the Plan. Therefore, the original claim determination was appropriate.

AR 54. Plaintiff filed the instant action on June 23, 2003.

II. Standard of Review

An ERISA administrator's denial of benefits under a plan is subject to *de novo* review unless the plan grants the administrator discretionary authority either to determine benefits or construe the terms of the plan. *Firestone Tire &*

Rubber Co. v. Bruch, 489 U.S. 101, 103 (1989). If the plan grants the administrator such discretion, the denial of benefits is subject to the highly deferential arbitrary and capricious standard of review. *Firestone*, 489 U.S. at 115.

Here, plaintiff expressly concedes that the plan grants the administrator discretion and that the plan administrator's decision is subject to the arbitrary and capricious standard of review. "[T]he arbitrary and capricious standard is the least demanding form of judicial review of administrative action." *Williams v. International Paper Co.*, 227 F.3d 706, 712 (6th Cir. 2000) A decision regarding eligibility for benefits is not arbitrary and capricious if it is "rational in light of the plan's provisions." *Daniel v. Eaton Corp.*, 839 F.2d 263, 267 (6th Cir. 1988). Stated differently, "[w]hen it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious." *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 693 (6th Cir. 1989) (internal quotations and citation omitted). The administrator's decision must be upheld if "it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Baker v. United Mine Workers of Am. Health and Retirement Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991).

> Nevertheless, merely because our review must be deferential does not mean our review must also be inconsequential. While a benefits plan may vest discretion in the plan administrator, the federal courts do not sit in review of the administrator's decisions only for the purpose of rubber stamping those decisions. As we observed recently, "[t]he arbitrary-and-capricious . . . standard does not require us merely to rubber stamp the administrator's decision." *Jones v. Metropolitan Life Ins. Co.*, 385 F.3d 654, 661 (6th Cir. 2004) (citing *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 172 (6th Cir. 2003)). Indeed, "[d]eferential review is not no review,

> and deference need not be abject." *McDonald*, 347 F.3d at 172. Our task at all events is to "review the quantity and quality of the medical evidence and the opinions on both sides of the issues." *Id.*

Moon v. Unum Provident Corp., 405 F.3d 373, 378-79 (6th Cir. 2005).

The Sixth Circuit has recognized that an actual conflict of interest exists when an insurer both decides whether an employee is eligible for benefits and pays those benefits. *Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 527 (6th Cir. 2003). "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone Tire & Rubber Co.*, 489 U.S. 101, 115 (1989)(quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). In the instant case, defendants decide whether a claimant is eligible for benefits, and pays those benefits. A conflict of interest therefore exists which must be considered as a factor when applying the abuse of discretion standard. The Court will consider and weigh this factor throughout the following discussion.

III. Discussion

Plaintiff argues that MetLife's decision to terminate her LTD benefits must be overturned in light of the arguments asserted by plaintiff's attorneys before the ALJ and the ALJ's finding that plaintiff was disabled. For this proposition, plaintiff relies primarily upon *Ladd v. ITT Corp.*, 148 F.3d 753 (7th Cir. 1998)(opinion by Posner, J.). The Sixth Circuit Court of Appeals summarized Ladd as follows:

> [I]n *Ladd v. ITT Corp.*, 148 F.3d 753, 755-56 (7th Cir. 1998), the Seventh Circuit held that the plan administrator's denial of disability benefits was arbitrary and capricious where none of the physicians who exam-

ined the plaintiff found that she was capable of working; the insurance company encouraged and assisted the plaintiff in applying for Social Security disability benefits, which were granted after an administrative law judge found that the plaintiff was totally disabled; and the plaintiffs condition was worse when the plan administrator denied her benefits under the plan than when she was granted Social Security benefits. In that case, after the plaintiff was awarded Social Security disability benefits, she was referred by MetLife to a doctor who worked for Network Medical Review Company, the same company employed by Fortis in this case. Without examining the plaintiff, the doctor for Network Medical Review concluded "in a perfunctory report that Ladd had sufficient 'residual, functional capacities' to work a full eight-hour day at a sedentary job." *Id.* at 755. On appeal, the Seventh Circuit found that "[t]he grant of social security benefits" had "additional significance:"

> It brings the case within the penumbra of the doctrine of judicial estoppel — that if a party wins a suit on one ground, it can't turn around and in further litigation with the same opponent repudiate the ground in order to win a further victory. The doctrine is technically not applicable here, because MetLife and ITT, the defendants in this suit, were not parties to the proceeding before the Social Security Administration. Yet they "prevailed" there in a practical sense because the grant of social security benefits to Ladd reduced the amount of her claim against the employee welfare plan. If we reflect on the purpose of the doctrine, which is to reduce fraud in the legal process by forcing a modicum of consistency on a repeating litigant, we see that its spirit is applicable here. To lighten the cost to the employee welfare plan of Ladd's disability, the defendants encouraged and supported her effort to demonstrate total disability to the Social Security Administration, going so far as to pro-

> vide her with legal representation. To further lighten that cost, it then turned around and denied that Ladd was totally disabled, even though her condition had meanwhile deteriorated. In effect, having won once the defendants repudiated the basis of their first victory in order to win a second victory. This sequence casts additional doubt on the adequacy of their evaluation of Ladd's claim, even if it does not provide an independent basis for rejecting that evaluation.

Id. at 756 (citations omitted).

Darland v. Fortis Benefits Ins. Co., 317 F.3d 516, 529-30 (6th Cir. 2003), *overruled on other grounds, Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003). Facing similar facts, and following *Ladd*, the court in *Darland* held that the principles of judicial estoppel weighed against the plan administrator taking "inconsistent positions." 317 F.3d at 530.

Here, as in *Ladd* and *Darland*, MetLife encouraged and assisted plaintiff in obtaining SSDB, and an ALJ found that plaintiff was disabled. Nonetheless, the Court finds that *Ladd* and *Darland* are distinguishable. In the instant case, the hearing before the ALJ was held on March 13, 2002. On that same day, plaintiff's treating physician, Dr. Patel, answered "yes" to MetLife's question "Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?" Dr. Patel's March 13, 2002 response was not part of the record before the ALJ. A statement by plaintiff's own physician indicating that she could perform sedentary work would clearly have been significant to any determination of total disability. MetLife cannot be bound by the proceedings before the ALJ or the ALJ's decision for the simple reason that the records before the ALJ and MetLife were materially different. The Court therefore concludes that *Ladd* and *Darland* are inapplicable.[3]

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[3] Further, it is unclear whether MetLife actually benefited from plaintiff's receipt of SSDB. As plaintiff points out in her reply brief, the Plan

Plaintiff also contends that MetLife was bound by its initial determination of total disability. At the time MetLife made its decision to terminate plaintiff's LTD benefits, the definition of "totally disabled" had changed from "unable to perform each of the material duties of [her] regular job" to include "unable to perform the duties of *any* gainful work . . . ." (emphasis added). Given the change in the definition of "totally disabled", plaintiff's argument is without merit.

Plaintiff additionally argues that it would be unfair to require her to return to work because if she attempts to work but cannot, she would lose her disability coverage. In making this argument, plaintiff refers to the statement of Dr. Pujara, who stated in part:

> However, based on Dr. Patel's own physical capacity evaluation on June 12, 2002, the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis. If the job environment entails [a] significant degree of emotional distress, and the patient is not able to cope with that, then certainly permanent disability can be considered.

AR 86. Thus, Dr. Pujara acknowledged the possibility that work-related emotional distress could prevent plaintiff from working. MetLife contends that the possibility that plaintiff's return to work may be unsuccessful would not be grounds to continue benefits, as the Plan insures only against actual disabilities, not possible future disabilities. The Court agrees. Read in context, Dr. Pujara's qualification is a recognition that the impact of real or perceived emotional stress is difficult to gauge. It was not an expression that plaintiff was incapable of sedentary work. In any event, the Plan does not alter the definition of "totally disabled" on the basis of a possible loss of coverage.

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gave MetLife the right to deduct SSDB regardless of whether plaintiff applied for them. AR 245.

Plaintiff maintains that the Court should enter judgment in her favor because MetLife did not give her the opportunity to respond to Dr. Pujara's report. Defendants argue that plaintiff was given the opportunity to submit her own supporting evidence in connection with her appeal, and that the plan administrator has the right to review that evidence with the assistance of a consultant. Defendants contend that if plaintiff had been given the opportunity to respond to Dr. Pujara's report with additional evidence, then MetLife would have had the right to seek review of that new evidence by a consultant, and the process would never end.

Plaintiff offers no authority for the proposition that Met Life's use of Dr. Pujara's report violated her rights under ERISA. Inasmuch as the process entails the interpretation of medical evidence, MetLife was entitled to enlist the help of a consultant to review that evidence. To require an opportunity to respond to every consultant's report would unduly burden the process. The Court finds that in the circumstances this case presents, ERISA did not require MetLife to provide plaintiff with a copy of Dr. Pujara's report and an opportunity to respond to the report before it issued its decision on plaintiff's appeal.

Defendants argue that MetLife's decision to terminate plaintiff's LTD benefits was rational and supported by substantial evidence. Plaintiff maintains that there is no evidence to support MetLife's decision.

On March 13, 2002, plaintiff's treating physician, Dr. Patel, answered "yes" to MetLife's question, "Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?" At the same time, Dr. Patel indicated that, in an eight-hour workday, plaintiff could sit eight hours, stand four hours, and walk two hours.

MetLife also had plaintiff's file reviewed by an independent physician consultant board certified in internal medicine,

Dr. Mark Moyer. Dr. Moyer concurred with Dr. Patel that plaintiff could perform sedentary work.

The vocational coordinator concluded that there were alternative sedentary occupations available in plaintiff's geographic area that plaintiff would be able to perform. These alternative occupations included account information clerk, attendance clerk, and classified ad clerk. In addition to considering plaintiff's physical limitations, the vocational coordinator specifically took into account Dr. Patel's statement that plaintiff should not be subjected to "emotional distress."

In a letter dated February 12, 2003, Dr. Patel stated:

> Previous reports filled out by me state that the patient was fit for sedentary work, however based on her clinical condition and her symptomatology, there was never a time where I felt that this patient would be able to return to full-time employment.

Hence, Dr. Patel expressly acknowledged that he had stated that plaintiff was fit for sedentary work. The Court finds that MetLife did not abuse its discretion by viewing Dr. Patel's recantation with skepticism. *See United States v. Willis*, 257 F.3d 636, 645-46 (6th Cir. 2001)(recognizing that affidavits recanting trial testimony are viewed with "extreme suspicion.").

MetLife also had before it Dr. Pujara's report. Dr. Pujara, a cardiologist, indicated "with the appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status." Dr. Pujara stated that plaintiff "has been relatively free of any significant cardiac compensation as documented by Dr. Patel's follow up notes." Dr. Pujara then concluded that plaintiff was "capable of sedentary activity as per the U.S. Department of Labor Guidelines." *Id.* Dr. Pujara additionally stated that plaintiff was "a reasonable candidate to try one of the sedentary job classes at least on a trial basis."

The Court finds that the above constitutes substantial evidence supporting MetLife's determination that plaintiff was no longer totally disabled as the Plan defines that term. Even considering MetLife's conflict of interest, the Court holds that MetLife's decision to terminate plaintiff's LTD benefits was rational and did not constitute an abuse of discretion. Defendants are therefore entitled to judgment in their favor.

IV. Disposition

Based on the above, the Court DENIES plaintiff s motion for entry of judgment and GRANTS defendants' cross-motion for entry of judgment.

The Clerk shall enter a final judgment in favor of defendants and against plaintiff, dismissing this action with prejudice.

The Clerk shall remove this case from the Court's pending cases list.

The Clerk shall remove Doc. 9, Doc. 11 and Doc. 12[4] from the Court's pending CJRA motions list.

IT IS SO ORDERED.

/s/ George C. Smith
GEORGE C. SMITH, JUDGE
United States District Court

[4] Doc. 11 and Doc 12 were improperly designated as motions. Doc. 10, which is a motion for judgment on the administrative record, was not docketed as a motion.

APPENDIX C

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

IN THE CASE OF	CLAIM FOR
Wanda Glenn (Claimant)	Period of Disability and Disability Insurance Benefits
_____ (Wage Earner)	587-84-9884 (Social Security Number)

DECISION

This case is before the undersigned Administrative Law Judge pursuant to a timely request for hearing. The claimant filed her application on August 11, 2000, alleging disability since April 30, 2000. This claim was denied initially on November 21, 2000 and upon reconsideration. After proper notice, a hearing was held on March 13, 2002 in Columbus, Ohio. The claimant appeared and testified and was represented by Valerie Barich. Gordon Snider, M.D., appeared and testified as a medical expert. Michael Klein, Ph.D., appeared and testified as a vocational expert.

ISSUES

The issues are whether the claimant is disabled as defined in the Social Security Act and, if so, when such disability commenced and the duration thereof; and whether the insured status requirements of the Act are met.

CONCLUSION

The claimant met the insured status requirements of the Act at all pertinent times and has been disabled as defined in the Act since April 30, 2000.

EVALUATION OF THE EVIDENCE AND RATIONALE

The claimant was born on December 11, 1952 and is 49 years old. She completed a high school education and past relevant

work was as a retail sales manager, material handler, sales person, teacher's assistant and investigator. In the disability report associated with her application, the claimant alleges the inability to work due to severe dilated cardiomyopathy (Exhibit 1E, p. 2). In the reconsideration disability report, she alleged that she continued to suffer from cardiomyopathy and high blood pressure. She related difficulty with tiredness and dealing with stress (Exhibit 6E, p. 1). At the hearing, the claimant complained of shortness of breath, fatigue and arm pain.

The claimant met the insured status requirements of the Act on April 30, 2000, the alleged onset date of disability, and continues to meet them through at least the date of this decision.

Social Security Regulations (20 CFR 404.1520 and 416.920) require a sequential evaluation process in disability cases. First, an individual who has engaged in substantial gainful activity cannot be found disabled. Second, an individual who does not have a "severe" impairment or combination of impairments is not disabled. Third, if an individual has an impairment that meets or equals the requirements of an impairment listed in Appendix 1 of Subpart P of the Regulations. (20 CFR 404) disability will be found without regard to vocational factors. Fourth, a determination must be made as to whether the claimant can do his or her prior work. If not, the burden shifts to the Commissioner and a fifth determination is made, namely, whether in light of the individual's residual functional capacity, age, education and past relevant work experience, the individual can perform other jobs that exist in significant numbers in the economy.

I find that the claimant has not engaged in substantial gainful activity since the alleged onset date of April 30, 2000.

Briefly, the relevant medical evidence demonstrates that the claimant has a history of systolic dysfunction indicated by

cardiac catheterization in 1993 (Exhibit 1F). Exercise myocardial perfusion scintigraphy in August 1996, demonstrated findings indicating a fixed septal defect consistent with prior myocardial infarction, left bundle branch block and/or AICD patch leads (Exhibit 2F).

More recent medical evidence includes an exercise stress test from March 8, 2000, with a base line electrocardiogram demonstrating left bundle branch block. Cardiac imaging on March 7, 2000 demonstrated left ventricular ejection fraction of 22 percent with findings indicative of underlying severe dilated cardiomyopathy. Cardiac catheterization on March 14, 2000 demonstrated an estimated ejection fraction of 25 percent.

Raj Patel, M.D., the claimant's treating cardiologist, reported on April 19, 2000, that the claimant suffered from severe dilated cardiomyopathy. She had significant difficulty with general fatigue and exertional shortness of breath because of her cardiac condition. He opined that she could not return to any kind of job that would require significant physical or psychological demands.

On June 20, 2000, Carl Leier, M.D., also a treating cardiologist, related the claimant's history including an episode of sudden death in October 1989 from which the claimant was resuscitated. At that time an AICD defibrillator system was placed for the prevention of additional sudden death/ malignant ventricular arrhythmia events. Dr. Leier reported that the claimant had gone on to develop a dilated cardiomyopathy with longstanding systemic hypertension. This condition has left her with biventricular enlargement and dysfunction. The dysfunction was systolic with likely diastolic dysfunction as well in view of the history of hypertension. He graded her overall functional class at that time as II to early III.

On July 28, 2000, Dr. Patel diagnosed the claimant with a history of idiopathic dilated cardiomyopathy and complex

ventricular arrhythmias requiring defibrillator. The claimant was feeling some improvement because of her reduction of stress and strain of work, however, she continued to experience periods of extreme fatigue (Exhibit 5F).

Reports from Choo Rhee, M.D., the claimant's treating internist since 1993, revealed the diagnoses of cardiomyopathy, hypertension, and defibrillator implant. Dr. Rhee opined that the claimant's physical activity was restricted (Exhibits 6F and 10F).

On December 15, 2000, Dr. Patel reported that the claimant continued to have good days and bad days but was mostly remaining out of any significant heart failure. Recently, her ICD was revised and she now had an ICD with three leads and biventricular pacing (Exhibit 9F, p. 2). On August 3, 2001, Dr. Patel reported that she looked clinically well compensated. However, he was concerned about her increasing general fatigue (Exhibits 9F and 11F).

An echocardiograph report of December 19, 2001 demonstrated an estimated ejection fraction of 35 to 40 percent. A pacemaker device was noted in the right heart (Exhibit 22F).

At the hearing, Dr. Snider, a Board-certified internist, testified as a medical expert. This testimony demonstrated a combination of impairments consisting of hypertensive vascular disease, history of sudden death syndrome, complex dysrhythmias and left bundle branch block, AICD implantation twice, dilated cardiomyopathy and systolic and diastolic ventricular dysfunction (Exhibit 23F). Dr. Snider opined that the claimant had no impairment or combination of impairments that met or equaled in severity the level of the Listings of Impairments in Appendix 1 to Subpart P of Regulations No. 4. Nevertheless, he opined that the claimant had significant functional loss. That is, the claimant is limited to lifting and carrying occasionally up to 15 pounds at a time and frequently two to three pounds at a time. The claimant could

stand and walk for three to four hours total during the workday. She could walk one half hour at a time for two to three times during the day. She could sit throughout the day with normal breaks. The claimant could only climb stairs at her own pace once or twice during the workday. She could occasionally bend and stoop but could not squat or crawl. She could not be at unprotected heights. The claimant must avoid smoke and fumes, extremes of heat and extremes of humidity. Her ability to operate foot controls is limited to 15 pounds occasionally and two to three pounds frequently. She could not balance. The claimant must avoid exposure to microwaves or electrical discharge. She is limited to low stress work environment.

The foregoing considered, I find that the medical evidence demonstrates the existence of impairments best described as hypertensive vascular disease, history of sudden death syndrome, complex dysrhythmias and left bundle branch block, AICD implantation twice, dilated cardiomyopathy and systolic and diastolic ventricular dysfunction. Although these impairments in combination are "severe" they do not meet or equal in severity the level of the listings of Impairments in Appendix 1 to Subpart P, Regulations No. 4, consistent with the testimony of the medical expert at the hearing.

I further find that the claimant is functionally limited as described by the medical expert, whose opinion I accept and adopt.

These impairments and resulting functional limitations are consistent with the medical record. They are as described by the medical expert in his testimony at the hearing. They are further documented by the claimant's extensive medical history and the diagnostic test results and clinical findings of record. They are generally consistent with the medical opinions of the claimant's treating physicians. The claimant's subjective complaints including shortness of breath and fatigue are supported by the medical opinions and medical

findings of record and are considered credible. The claimant's credibility is further enhanced by her excellent work and earnings record.

The record contains residual functional capacity assessments relating to the claimant completed by physicians employed by the State Disability Determination Services ("DDS"). Those opinions were relied on in denying the claimant's application at the initial and reconsideration levels, and conflict with the residual functional capacity finding reached in this decision. The main reason for not adopting those opinions is that new persuasive evidence regarding the nature and severity of the claimant's impairments has been received, including extensive treatment records from treating sources as well as the testimony of the medical expert at the hearing. It is quite possible that the DDS opinions would differ had those physicians had the opportunity to evaluate that new evidence.

The remaining issue is whether the claimant's impairments prevent her from performing past work or other kinds of substantial gainful activity. The claimant bears the burden of showing inability to perform her prior work, but once this burden is met it shifts to the Commissioner to show that there are other jobs that the claimant can perform which exist in significant numbers in the economy.

Dr. Klein, the vocational expert at the hearing, identified the claimant's prior jobs a retail sales manager, material handler, sales person, teacher's assistant and investigator. The prior jobs as a sales person, teacher assistant and investigator were all exertionally light and semi-skilled. The prior job as the retail sales manager was exertionally light and skilled and the work as a material handler was exertionally medium and unskilled. The testimony of the vocational expert is consistent with the description of the jobs in the *Dictionary of Occupational Titles*.

Consistent with the claimant's impairments and resulting functional limitations, the vocational expert opined that indi-

viduals so impaired could not perform any of the claimant's past relevant work. The vocational expert identified no transferable skills to other skilled or semi-skilled jobs within the claimant's residual functional capacity. Considering the claimant's residual functional capacity and her vocational profile, the vocational expert opined that this indicated a non-competitive work capacity. That is, the vocational expert opined that this combination of functional limitations would effectively preclude the performance of full-time competitive employment. The testimony of the vocational expert is considered accurate and is accepted and adopted.

Accordingly, I find that the claimant has been prevented by her impairments and resulting functional limitations from performing any past relevant work. She has not acquired transferable skills to other skilled or semi-skilled work within her residual functional capacity. Considering the claimant's residual functional capacity and her vocational profile, the claimant is prevented from performing any jobs existing in significant numbers in the national economy consistent with the testimony of the vocational expert. The claimant then, has been disabled as defined in the Social Security Act since April 30, 2000, pursuant to 20 CFR 404.1520(f).

FINDINGS

1. The claimant met the insured status requirements of the Act on April 30, 2000, the alleged onset date of disability, and continues to meet them through at least the date of this decision.

2. The claimant has not engaged in substantial gainful activity since April 30, 2000.

3. The claimant has a severe combination of impairments consisting of hypertensive vascular disease, history of sudden death syndrome, complex dysrhythmias and left bundle branch block, AICD implantation twice, dilated

cardiomyopathy and systolic and diastolic ventricular dysfunction.

4. The claimant has no impairment or combination of impairments listed in or medically equal to one listed in Appendix 1, to Subpart p of Regulations No. 4.

5. The claimant's subjective complaints have been carefully considered and are felt to be reasonably supported by the medical record and generally credible.

6. The claimant's impairments since April 30, 2000 have limited her to lifting and carrying occasionally up to 15 pounds at a time and frequently two to three pounds at a time. The claimant could stand and walk for three to four hours total during the workday. She could walk one half hour at a time for two to three times during the day. She could sit throughout the day with normal breaks. The claimant could only climb stairs at her own pace once or twice during the workday. She could occasionally bend and stoop but could not squat or crawl. She could not be at unprotected heights. The claimant must avoid smoke and fumes, extremes of heat and extremes of humidity. Her ability to operate foot controls is limited to 15 pounds occasionally and two to three pounds frequently. She could not balance. The claimant must avoid exposure to microwaves or electrical discharge. She is limited to low stress work environment.

7. The claimant's impairments and resulting functional limitations prevent the performance of any past relevant work.

8. The claimant is a younger person and has a high school education.

9. The claimant has a history of skilled and semi-skilled work but has not acquired transferable skills to other skilled or semi-skilled work within her residual functional capacity.

10. Considering the claimant's residual functional capacity and her vocational profile, she is prevented from performing any jobs existing in significant numbers in the national economy, consistent with the testimony of a vocational expert.

11. The claimant has been disabled as defined in the Social Security At since April 30, 2000 pursuant to 20 CFR 404.1520(f)

DECISION

Based on the application filed August 11, 2000, the claimant is entitled to a period of disability commencing April 30, 2000, and to disability insurance benefits under Sections 216(i) and 223, respectively, of the Social Security Act, and the claimant's disability has continued through the date of this decision.

/s/ Thomas P. Piliero
THOMAS P. PILIERO
Administrative Law Judge

April 22, 2002
Date

FILED
MAR 7 - 2007
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 06-923

IN THE

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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March 7, 2007

QUESTIONS PRESENTED

(1) Whether an ERISA plan fiduciary's refusal to consider a Social Security Administration (SSA) decision finding a beneficiary "disabled" should be considered as a factor in the judicial review of a termination of benefits, when the fiduciary encouraged, assisted, and retained counsel for the beneficiary in the SSA proceedings for its own financial gain.

(2) Whether an ERISA plan fiduciary that funds benefits, makes benefits determinations, and encourages and assists a beneficiary in obtaining Social Security disability benefits for its own financial gain, then subsequently terminates plan benefits by arbitrarily refusing to consider reliable evidence of the beneficiary's treating physician as well as an SSA decision finding the beneficiary "disabled," acts under a "conflict of interest" that must be weighed as a factor in the judicial review of a termination of benefits.

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STATEMENT OF THE CASE

This case involves an insurance company, Petitioner Metlife, that makes benefits determinations and pays any benefits it grants (hereinafter, a "dual-role insurer") for Sears, Roebuck, and Company ("Sears") under an employee benefit plan governed by ERISA. For its own financial benefit, Metlife encouraged, assisted, and retained counsel for the Respondent, Ms. Wanda Glenn, to obtain disability benefits from the Social Security Administration ("SSA"). Nonetheless, shortly after Metlife received its reimbursement payment from Ms. Glenn of the retroactive SSA benefits awarded to her, Metlife terminated all the benefits it had been paying her. In so doing, Metlife refused to consider, no less refute, the SSA's decision finding Ms. Glenn "disabled." Additionally, Metlife arbitrarily relied upon hand-picked portions of the administrative record and ignored reliable evidence from Ms. Glenn's treating physician that she was unable to work at any job.

Under this Court's decision in *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101 (1989), and consistent with the law of *every circuit interpreting Firestone*, Metlife's effective participation in the SSA proceedings and its subsequent failure to consider the SSA decision in terminating Ms. Glenn's benefits constitutes: (i) a factor that must be weighed in judicial review under *Firestone*; and (ii) in concert with numerous other unjustified actions of Metlife recounted in detail below, evidence of an actual conflict of interest and "arbitrary and capricious" behavior, commanding reversal of its denial of benefits determination.

Therefore, the putative splits of authority among the circuit courts regarding—(i) whether an ERISA fiduciary, *which does not require, assist, or encourage a beneficiary to obtain Social Security disability benefits for its own financial gain*, must consider an SSA decision; and (ii) whether a mere dual-role insurer, *with no additional evidence of a conflict of interest*, acts under an inherent conflict that must be considered in the judicial review of a denial a benefits—are not implicated in this case. Moreover, the Sixth Circuit's holding squarely applies this Court's precedent. Finally, even disregarding Metlife's conflict of interest and its failure to consider the SSA decision, its refusal to consider, no less refute, reliable evidence of Ms. Glenn's treating physician, alone renders its actions "arbitrary and capricious."

1. Petitioner Wanda Glenn, who is 54 years old, joined Sears in 1986, and was ultimately promoted in 1994 to sales manager of the women's department, where she maintained an excellent work and earnings record. Pet. App. 2a, 28a, 41a, 46a. Ms. Glenn was covered under Sears's long-term disability plan ("the plan"). *Id.* at 3a, 27a.

Ms. Glenn has a long history of cardiac and related illnesses. In the early 1980s, Ms. Glenn developed hypertension and has been treated with anti-hypertension drugs since at least 1985. *Id.* at 4a. In 1989, she underwent "sudden cardiac death" but fortunately was resuscitated. *Id.* Shortly thereafter, a defibrillator was implanted to counteract her abnormal heart rhythms. *Id.* In the 1990s, after being diagnosed with left ventricular dysfunction, she was hospitalized twice. *Id.* In 2000, she started to experience symptoms of prolonged chest tightness, shortness of breath, "increasing fatigue by the end of the day," and edema in her legs from "prolonged standing at work." *Id.*

In March 2000, as Ms. Glenn's ventricular dysfunction worsened, her treating cardiologist, Dr. Rajendra C. Patel, diagnosed her with severe dilated cardiomyopathy, a condition causing weakness in the heart muscle, which he considered related to her job at Sears. *Id.* at 4a, 29a, 43a. Ms. Glenn undertook many attempts to improve her condition, taking as many as seven or eight different medications. *Id.* at 5a. However, her condition deteriorated, and on April 30, 2000, Dr. Patel opined, "From my standpoint, this patient cannot return to any kind of job that would require any significant physical or psychological stress." *Id.* at 3a. At the end of April, Ms. Glenn took medical leave from Sears. *Id.* at 5a.

On June 20, 2000, Dr. Carl Leier, a specialist in cardiovascular disease at the Ohio State College of Medicine, reported upon examination that Ms. Glenn's cardiomyopathy resulted in cardiac dysfunction that limited her ability to work. *Id.* That same day, Ms. Glenn submitted a disability claim under the plan. *Id.* at 3a. Metlife, the claims administrator of Sears's plan,[1] approved Ms. Glenn's claim, and after a 140-day elimination period, she began receiving benefits directly from Metlife. *Id.*

In August 2000, Ms. Glenn applied for Social Security Benefits. *Id.* at 3a. On October 10, 2000, Metlife informed Ms. Glenn by letter that it provided her name to a law firm, Kennedy & Associates, which specializes in securing Social Security disability benefits. *Id.* at 11a; J.A. 31-32. In the October 10 letter, Metlife also instructed Ms. Glenn to "contact Kennedy & Associates in

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[1] Technically, Metlife is the "plan fiduciary" and "claims administrator" of the plan, while Sears is the "plan administrator." Joint Appendix ("J.A.") 37. In any event, Metlife both makes benefits determinations and pays those benefits. J.A. 44. (The Joint Appendix consists of material submitted in Ms. Glenn's action in the Sixth Circuit.)

the near future." J.A. 32. Finally, Metlife informed Ms. Glenn that if she secured "a retroactive award, a recalculation of [Metlife's disability] benefits would be performed," such that she would be responsible for reimbursing Metlife for any "overpayment." *Id.* Metlife failed to notify Ms. Glenn that any future benefits would also be recalculated, subject to a 100% offset from any benefits received by her from the SSA. *Id.*; Administrative Record ("A.R.") 16-17.[2] In December 2000, Kennedy & Associates informed Metlife that Ms. Glenn had retained its services, and it requested all of Ms. Glenn's records in Metlife's files. J.A. 354. Later that month, Metlife forwarded the records. *Id.* at 338-39, 356.

In the meantime, Ms. Glenn underwent further examinations. Pet. App. 5a. In November 2000, Dr. Patel informed Metlife that Ms. Glenn was completely disabled from performing any occupation and that he did not expect her to be able to return to work. *Id.* Nearly one year after Ms. Glenn stopped working, in March 2001, Dr. Patel reported "some improvement in her LV [left ventricular] function." *Id.* Yet, Dr. Patel noted that she "still gets fatigued out and short of breath, particularly if she is under any kind of significant psychologic stress." *Id.* On August 3, 2001, Dr. Patel indicated that Ms. Glenn looked clinically well, but he was concerned about increasing general fatigue. *Id.* at 44a.

Nearly two years after stopping work, on March 13, 2002, Dr. Patel indicated on a Metlife form that Ms. Glenn could now, in a day, sit for eight hours, stand for four hours, and walk for two hours. *Id.* at 5a, 29a. Importantly, Dr. Patel also checked a "yes" box on the form stating that the insured is "able to work in a

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[2] The Administrative Record consists of material submitted by the parties in the district court proceedings.

sedentary physical exertion level occupation." *Id.* at 5a. Although the form was intended to assess Ms. Glenn's capacity to return to work full-time, Dr. Patel signed the form without indicating whether he was releasing Ms. Glenn to return to work or if any restrictions applied. *Id.* at 5a-6a.

The same day, March 13, 2002, an administrative law judge ("ALJ") held a hearing to determine whether Ms. Glenn was "disabled" under the Social Security Act. *Id.* at 41a. Ms. Glenn was represented by Valerie Barich, an attorney from Kennedy & Associates. *Id.* On, April 22, 2002, the ALJ issued a decision finding that Ms. Glenn was disabled as of April 30, 2000. *Id.* at 41a, 49a. In so doing, the ALJ relied on evidence submitted by Metlife via Kennedy & Associates to the SSA, additional medical records of Ms. Glenn's, plus the assessments of Dr. Snider, a Board-certified internist, and Dr. Klein, a vocational expert, both hired by the SSA. *Id.* at 44a, 46a. Dr. Snider testified that Ms. Glenn had a history of sudden death syndrome, complex dysrhythmias, dilated cardiomyopathy, and ventricular dysfunction resulting in "significant functional loss." He concluded that Ms. Glenn "is limited to [a] low stress work environment." *Id.* at 44a-45a. Dr. Klein testified that Ms. Glenn's limited "functional capacity" and "vocational profile" precluded "the performance of full-time competitive employment." *Id.* at 47a. The ALJ ordered the retroactive payment of benefits from October 2000, plus the payment of benefits going forward. *Id.* at 3a, 49a.

Under Metlife's plan, to receive disability payments for the first 24 months, Ms. Glenn had to be "completely and continuously unable to perform each of the material duties of *[her] regular job*." Pet. App. 3a, 28a (emphasis added). In order to continue receiving payments after the first 24 months, Ms. Glenn had to be "completely and continuously unable to perform the duties of *any gainful*

work or service for which [she is] reasonably qualified." *Id.* (emphasis added). A few months before the initial 24-month period was to expire, on May 20, 2002, Metlife sent Ms. Glenn a letter informing her that in order to continue receiving her benefits, she would need to demonstrate that she met this changed definition of disability. *Id.* at 3a-4a. The letter further noted that Metlife would review "[Ms. Glenn]'s vocational information, medical information and [her] specific restrictions and limitations that are supported by objective medical evidence." *Id.* at 4a.

On June 18, 2002, Kennedy & Associates sent Metlife a letter detailing the breakdown of Ms. Glenn's $17,738 award of retroactive disability benefits from the Social Security Administration. J.A. 320. Under the plan, Ms. Glenn was obligated to reimburse Metlife for the full amount of past due benefits. A.R. 9; 17. Despite this obligation, Metlife allowed $4,434.50 of Ms. Glenn's past-due benefits to be used to pay for her legal fees. A.R. 73-74; J.A. 320-21. Later, Metlife demanded reimbursement for overpayment of benefits for the remaining amount, $13,303.50, which Ms. Glenn paid to Metlife in installments. Pet. App. 4a, 11a; A.R. 42, 60, 61, 70-74. Additionally, on-going amounts owed to Ms. Glenn by Metlife were reduced by approximately 100% of her continuing SSA benefits. A.R. 40-41; J.A. 320. In a July 8, 2002 letter, Kennedy & Associates thanked Metlife: "As always, we greatly appreciate the opportunity to provide you [sic] insured with an effective means by which to secure their [sic] Social Security benefits, and we look forward to your future referrals." J.A. 313.

On June 12, 2002, Dr. Patel reiterated his opinion of March 13, 2002, that Ms. Glenn was able to sit eight hours, stand four hours, and walk two to four hours on a Metlife form, but cautioned "No emotional stress/No heavy exertion." Pet. App. 6a, 30a. Just six days later, on

June 18, 2002, Dr. Patel sent a progress report to Ms. Glenn's internist, Dr. Choo Rhee, indicating that Ms. Glenn "was back in our office earlier than expected," complaining of fatigue, "shortness of breath on moderate exertion," and "significant anxiety . . . regarding the disability and having to return to work." *Id.* at 6a. Dr. Patel concluded, "From my standpoint, again, considering her cardiomyopathy, I do not believe she will handle any kind of stress well at her work and she would be better off being on disability." *Id.*

Metlife hired an outside physician, Dr. Mark Moyer, merely to review Ms. Glenn's file, but not to examine her—despite Metlife's right under the plan to do so. *Id.* at 19a, 30a; A.R. 20, 39. Apparently ignoring Dr. Patel's report from June 18, 2002, concluding that Ms. Glenn was unable to work, Dr. Moyer focused on Dr. Patel's earlier (and, by then, outdated) assessment from March 13, 2002, that Ms. Glenn could perform sedentary work. Pet. App. 30a; A.R. 39. Based on this evaluation, a vocational rehabilitation coordinator determined that Ms. Glenn could function as an account information clerk, attendance clerk, and classified ad clerk. Pet. App. 30a. On July 15, 2002, Metlife informed Ms. Glenn that her last day of benefits would be September 16, 2002. *Id.*

On July 26, 2002, Ms. Glenn requested that Metlife reconsider its decision. *Id.* at 31a. As support, she submitted a July 22, 2002, letter to Metlife, in which Dr. Patel reaffirmed his view that Ms. Glenn should not return to work:

> [Ms. Glenn] continues to have significant difficulty in returning to even any kind of sedentary job because any kind of psychologic stress at work causes significant problems with her cardiovascular condition . . . .

> At the present time, I do not believe Wanda should be forced to return to any kind of even sedentary work .... The patient basically should be considered completely disabled from her dilated cardiomyopathy as well as history of ventricular tachycardia.

Id. at 6a-7a.

On August 28, 2002, Metlife denied Ms. Glenn's request for reconsideration, and notified her that her long-term benefits would be terminated on September 16, 2002, based on the decision that "[t]here is no supportive medical documentation of the exacerbation of your cardiac condition and symptomology, due to subjective complaints of work-related stress." *Id.* at 7a. The letter concluded that the "records submitted for review do not support cardiovascular impairment that would prevent you from performing full time sedentary work." *Id.* Metlife relied upon Dr. Patel's reports from November 2001 and March 13, 2002, indicating Ms. Glenn's improving condition and ability to perform sedentary work. *Id.* However, the letter failed to address Dr. Patel's report from June 18, 2002, and letter from July 22, 2002, noting that Ms. Glenn's improved condition was short-lived, and concluding that she was "completely disabled" and unable "to return to any kind of even sedentary work." *Id.* at 6a-7a; A.R. 67-69. Metlife also failed to consider the SSA's then-recent decision finding Ms. Glenn "disabled." Pet. App. 7a, 11a, A.R. 67-69.

On February 12, 2003, Ms. Glenn appealed Metlife's denial of continued benefits. Pet. App. 31a. Dr. Patel sent a letter that day to Metlife stating that:

> Previous reports filled out by me state that the patient was fit for sedentary work, however based on her clinical condition and her symptomology, there was never a time I felt that this patient

> would be able to return to *full-time employment*. . . . My position is that she should be considered completely disabled.

Id. at 7a (emphasis added). In response, Metlife hired an outside consultant physician, Dr. Chandrakant Pujara, not to conduct an examination of her, but merely to review Ms. Glenn's medical records. *Id.* at 8a. Although Dr. Pujara concluded that Ms. Glenn could not engage in "exertional physical activity," he focused on Dr. Patel's early evaluation from June 12, 2002, to conclude that "the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis."[3] *Id.* On the other hand, Dr. Pujara noted that "[i]f the job environment entails [a] significant degree of emotional stress, and the patient is not able to cope with that, then certainly permanent disability can be considered." *Id.* Dr. Pujara failed to address Dr. Patel's diagnoses from June 18, 2002, July 22, 2002, and February 12, 2003, concluding that Ms. Glenn was "completely disabled" and not able to work at "any kind" of job. *Id.*; A.R. 85-86, 90-91.

Despite Dr. Pujara's inconclusive report, Metlife issued a final denial of disability benefits on May 20, 2003. Pet. App. 8a. Like Dr. Pujara, Metlife relied upon Dr. Patel's report from June 12, 2002, but failed to address his diagnoses of disability from June 18, 2002, and July 22, 2002. *Id.* Although Metlife acknowledged Dr. Patel's letter from February 12, 2003, it concluded that the "documentation on file does not support a disability that would prevent Ms. Glenn from performing any occupation, as defined in the plan." *Id.*

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[3] Petitioners conceded at oral argument in the Sixth Circuit that "[Ms.] Glenn had not been offered a part-time position at Sears and that she would have no chance of receiving benefits under the Sears ERISA plan if she went to work for another employer on the trial basis that Dr. Pujara suggested." Pet. App. 18a n.2.

Having exhausted her contractual appeals with Metlife, Ms. Glenn filed suit in federal court under ERISA, 29 U.S.C. § 1132(a)(1)(B), to recover and reinstate the benefits owed to her. *Id.* at 8a-9a. On June 8, 2005, the district court affirmed Metlife's denial of benefits. In so doing, the district court considered the Seventh Circuit's opinion in *Ladd v. ITT Corp. and Metropolitan Life Insurance Co.*, 148 F.3d 753, 755-56 (7th Cir. 1998) (Posner, J.), which held that a plan administrator's (in fact, Metlife's) decision was "arbitrary and capricious" where:

> [N]one of the physicians who examined the plaintiff found that she was capable of working; the insurance company encouraged and assisted the plaintiff in applying for Social Security disability benefits, which were granted after an administrative law judge found that the plaintiff was totally disabled; . . . the plaintiff's condition was worse when the plan administrators denied her benefits under the plan than when she was granted Social Security benefits; [and] the doctor [conducting the independent review for Metlife] concluded in a perfunctory report that [the beneficiary] had sufficient residual, functional capacities to work a full-eight hour day at a sedentary job.

Id. at 35a (quoting *Ladd*, 148 F.3d at 755) (internal quotation marks omitted). The district court quoted with approval Judge Posner's rationale of the "penumbra of the doctrine of judicial estoppel" as applying in these circumstances:

> [I]f a party wins a suit on one ground, it can't turn around and in further litigation with the same opponent repudiate the ground in order to win a further victory. The doctrine is technically not applicable here, because Metlife and ITT, the defendants in this suit, were not parties to the

> proceeding before the Social Security Administration. Yet, they "prevailed" there in a practical sense because the grant of social security benefits to [the beneficiary] reduced the amount of her claim against the employee welfare plan. If we reflect on the purpose of the doctrine, which is to reduce fraud in the legal process by forcing a modicum of consistency on a repeating litigant, we see that its spirit is applicable here. To lighten the cost of the employee welfare plan . . . the defendants encouraged and supported [the beneficiary's] effort to demonstrate total disability to the Social Security Administration, going so far as to provide her with legal representation. . . . This sequence casts additional doubt on the adequacy of [Metlife's and ITT's] evaluation of [the beneficiary's] claim, even if it does not provide an independent basis for rejecting that evaluation.

Id. at 35a-36a (quoting *Ladd*, 148 F.3d at 756).

The district court then noted that *Ladd* is controlling precedent in the Sixth Circuit by its adoption in *Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 529-30 (6th Cir. 2003). *Id.* at 36a. Additionally, the district court found that like Metlife's behavior in *Ladd*, in this case, "Metlife encouraged and assisted plaintiff in obtaining [Social Security disability benefits], and an ALJ found that plaintiff was disabled." *Id.* Yet, the district court distinguished *Ladd* on the ground that the ALJ did not have access to Dr. Patel's response from March 13, 2002, checking "yes" on the Metlife form that Ms. Glenn could perform sedentary work, because that form was filled out the same day as the SSA hearing. *Id.* The district court rejected other of Ms. Glenn's arguments and entered judgment in favor of Metlife. *Id.* at 37a-40a.

2. Ms. Glenn appealed to the Sixth Circuit, which on September 1, 2006, reversed the judgment of the district

court and remanded with instructions to reinstate Ms. Glenn's disability benefits, retroactive to the date of termination. *Id.* at 1a, 25a-26a.

First, the panel determined that the district court failed to give adequate consideration to Metlife's refusal to review the SSA decision. *Id.* at 11a. In particular, the panel found that:

> Metlife . . . steered [Ms. Glenn] to a law firm . . . . deducted the amount of [the] government benefits from the disability payments that it was obliged to pay and demanded a refund from Glenn in the amount of $13,500. And, yet, in making the decision to terminate payments under the Metlife policy, the plan administrator gave no weight whatever to the Social Security Administration's determination of total disability.

Id. The panel then held that "[i]t is obvious that both factors are relevant in determining whether Metlife's decision is arbitrary and capricious," citing *Ladd*. *Id.* at 12a-13a. The panel further held:

> "[A] plan administrator's decision denying disability benefits where the Social Security Administration has determined that the applicant was totally disabled" can be considered arbitrary and capricious, especially where "it is plainly evident that the Social Security standard for a disability determination is much more stringent than that required by [the defendant's] insurance policy." The latter observation . . . pertains in this case to the language of the policy . . . .

Id. at 13a-14a (quoting *Darland*, 317 F.3d at 529-30). The panel then rejected the district court's reliance on Dr. Patel's March 13, 2002, checking of the "yes" box, indicating that Ms. Glenn could perform "sedentary"

work, because of Dr. Patel's later clarification that "he had never considered his patient capable of resuming full-time work." *Id.* at 14a. Next, the panel faulted Metlife for financially benefiting from Ms. Glenn's "receipt of Social Security benefits," then failing to "give[] appropriate weight to [the SSA] determination." *Id.* The panel concluded that Metlife's "failure to consider the [SSA's] finding of disability . . . *does not render the decision arbitrary per se*, but it is obviously a significant factor to be considered upon review." *Id.* at 15a (emphasis added).

Second, the panel described as "even more perplexing" Metlife's "failure to give any weight to Dr. Patel's letters of July 22, 2002, and February 12, 2003, in which he clearly stated that he did not believe Glenn was capable to work, sedentary or otherwise." *Id.* at 15a. The panel went on to recount Metlife's selective consideration of the evidence, particularly its reliance on physicians who never actually examined Ms. Glenn. *Id.* at 15a-18a. Under this Court's decision in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003), the panel noted that Metlife "need not accord special deference to the opinion of a treating physician," but "[b]y the same token, it may not arbitrarily repudiate or refuse to consider the opinions of a treating physician." *Id.* at 20a. Particularly "critical" was Metlife's "failure to consider evidence that [was] offered after [the] initial denial of benefits," because such an omission "renders a final denial of benefits arbitrary and capricious." *Id.* at 20a-21a.

Although the panel found that Metlife's refusal to consider evidence submitted by Ms. Glenn after the initial denial of benefits was itself "arbitrary," it concluded its opinion by recounting numerous other factors rendering Metlife's decision "arbitrary and capricious." *Id.* at 25a. These factors included: Metlife's actual "conflict of interest" stemming from its status as a dual-role insurer;

its "unacknowledged conflict with the determination of disability by the [SSA]"; its "selective consideration of [Ms.] Glenn's medical record"; its failure to provide its "independent medical consultant" the full information from Ms. Glenn's treating physician; and its failure "to factor in . . . the role that stress played in aggravating her condition." *Id.* at 25a. The panel reversed, and the majority remanded with instructions to reinstate Ms. Glenn's benefits. *Id.* at 26a.

On January 2, 2007, Petitioners timely filed a petition for certiorari. This brief in opposition followed.

REASONS FOR DENYING THE WRIT

At best, the petitioners demonstrate that there is a split of authority among the circuits on two issues: (i) whether a mere ERISA fiduciary, *which does not require, assist, or encourage a beneficiary to obtain SSA benefits*, must consider an SSA's decision finding a beneficiary "disabled" when terminating that beneficiary's benefits; and (ii) whether a mere dual-role insurer, *which does not categorically refuse to consider reliable evidence of the beneficiary's treating physician as well as an SSA decision finding the beneficiary "disabled,"* is subject to a conflict of interest that must be considered in the judicial review of a denial of benefits.

Not surprisingly, the Petitioners fail to point out the limiting conditions of the italicized clauses in the previous paragraph. Because these conditions are not met by the facts here, there are no splits of authority implicated in this case. Additionally, the Sixth Circuit's decision is consistent with the law of this Court.

Finally, even disregarding Metlife's conflict of interest and its failure to consider the SSA decision, its repeated refusals even to consider, no less refute, reliable evidence of Ms. Glenn's treating physician, render its actions "arbitrary and capricious."

I. Because Metlife Retained Counsel for Ms. Glenn in the SSA Proceedings, No Split of Authority is Implicated in this Case on the Issue of Whether Metlife was Required to Consider the SSA Decision

No split of authority regarding Metlife's failure to consider the SSA decision is implicated in this case, because of Metlife's effective participation in the SSA proceedings. As detailed above and as found by the Sixth Circuit, a law firm, Kennedy & Associates, was "retained by Metlife to represent [Ms.] Glenn before the Social Security Administration." Pet. App. 21a. Indeed, Metlife not only referred Ms. Glenn to Kennedy & Associates, but freely submitted substantial evidence to Kennedy & Associates to provide to the SSA, received reimbursement from Ms. Glenn's SSA benefits for "overpayment" under the plan, and effectively paid for Ms. Glenn's legal fees from a portion of this reimbursement amount owed to it. *See supra* pp. 6-7.

Shortly after retaining counsel for Ms. Glenn, and taking the retroactive SSA benefits awarded to her, Metlife terminated Ms. Glenn's plan benefits. As the Sixth Circuit found, despite the fact that the SSA standard of "disability" is "much more stringent than that required by [Metlife's] insurance policy," *id.* at 13a, and despite evidence showing Ms. Glenn's condition worsened following the SSA hearing, *id.* at 6a, 30a, Metlife refused to consider the SSA decision in terminating Ms. Glenn's benefits, *id.* at 11a.

Only two circuits have addressed a case with these facts. In *Ladd v. ITT Corp. and Metlife*, as described above, Judge Posner, writing for the Seventh Circuit, adopted a "penumbra of judicial estoppel" rationale, whereby Metlife's effective participation in the SSA proceedings on behalf of the beneficiary, "cast[ed] ... doubt on the adequacy of [Metlife's] evaluation of [the beneficiary's] claim." 148 F.3d at 756.[4] Along with other salient facts, the Seventh Circuit ultimately found Metlife's decision "arbitrary and capricious." These facts included that "no one who examined Ladd . . . believed she was capable of working" and that Ladd's condition had worsened since the SSA decision. 148 F.3d at 754-756.[5]

In *Darland*, the Sixth Circuit adopted Judge Posner's "penumbra" rationale, where the beneficiary applied for SSA benefits "at [the insurer's] insistence" in order "to reduce the amount of monthly disability payments that it paid [the beneficiary] under the plan." 317 F.3d at 528-30. The Sixth Circuit reasoned, "As in *Ladd*, it is totally inconsistent for [the insurer] to request that [the beneficiary] apply for Social Security disability benefits, yet avail itself of that Social Security determination regarding disability to contend, at the same time, that he is not disabled. Though not directly applicable in this case, the principles of judicial estoppel certainly weigh

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[4] In so holding, the Seventh Circuit relied upon the fact that the SSA definition of "total disability" and the plan's definition were effectively similar. 148 F.3d at 754. The clause at issue under Metlife's policy in *Ladd* is essentially the same as the clause at issue in this case. *Id.*; Pet. App. 13a.

[5] Notably, the only physicians who actually examined Ms. Glenn to determine whether she was disabled were ultimately all of the opinion that she could not work at *any* job. *See supra* pp. 6-10. Additionally, Dr. Patel's diagnoses indicated that Ms. Glenn's condition worsened from the date of the SSA hearing. *See* Pet. App. 6a, 30a.

against [the insurer] taking such inconsistent positions." *Id.*

Both *Ladd* and *Darland* squarely fit the facts in this case. However, none of the other decisions cited by Petitioners to show an alleged "conflict" among the circuits address the facts here. Pet. 17-19. In *Conley v. Pitney-Bowes*, 176. F.3d 1044, 1050 (8th Cir. 1999), the court refused to consider adopting the *Ladd* rule, precisely because "[t]he doctors who examined [the beneficiary] were not unanimous, and the defendants did not help make his case to the Social Security Administration." Similarly, in *Whitaker v. Hartford Life & Accident Ins. Co.*, 404 F.3d 947 (6th Cir. 2005), in rejecting the claimant's argument that, under *Darland*, an administrator must in *all* cases "explicitly distinguish a favorable SSA determination when denying plan disability benefits," the court noted *Darland* was a "*unique situation* . . . where it would be inconsistent for a plan administrator to ignore the SSA's favorable determination, after the administrator had expressly requested the claimant to apply for SSA benefits." *Id.* at 949 (emphasis added).

The remaining cases cited by Petitioner are similarly unavailing. *See Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1455-56 (D.C. Cir. 1992) (holding that an SSA decision issued after a rejection of benefits by an ERISA administrator would be accorded "no weight," but providing no indication whether the insurer encouraged or assisted in the SSA proceedings); *Pari-Fasano v. ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 420 (1st Cir. 2000) (holding that an SSA decision "might be relevant to an insurer's eligibility determination," but providing no indication whether the insurer encouraged or assisted in the SSA proceedings); *Paese v. Hartford Life and Accident Ins. Co.*, 449 F.3d 435, 442-443 (2d Cir. 2006) (similar); *Donato v. Metropolitan Life Ins. Co.*, 19

F.3d 375, 380 (7th Cir. 1994) (holding that an insurer was not obligated to review medical evidence in a Social Security file that it never had before it, but providing no indication whether the insurer encouraged or assisted in the SSA proceedings); *Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279, 1285 (9th Cir. 1990) (holding that an insurer's failure to "consider [the beneficiary's] social security award was not "arbitrary and capricious" where the medical evidence relied upon by the SSA was out-of-date, but providing no indication whether the insurer encouraged or assisted in the SSA proceedings).

The soundness of Judge Posner's "penumbra" rationale is reinforced by *Black & Decker Disability Plan v. Nord*, where this Court recognized that ERISA "require[s] *'full and fair'* assessment of claims and clear communication to the claimant of 'specific reasons' for benefit denials." 538 U.S. at 825 (citing 29 U.S.C. § 1133) (emphasis added). Although this Court noted certain "differences between the Social Security disability program and ERISA benefit plans," it cautioned that "[p]lan administrators, of course, may not arbitrarily refuse to credit a claimant's *reliable* evidence . . . ." 538 U.S. at 833-834 (emphasis added). Indeed, the plan covering Ms. Glenn clearly states that Metlife "will re-evaluate *all the information*" in its files upon a request for review following a denial of claims. A.R. 23-24 (emphasis added).

Considering the viability of *Ladd* and *Darland* following this Court's decision in *Black & Decker*, in *Calvert v. Firstar Fin. Inc.*, 409 F.3d 286 (6th Cir. 2005), the Sixth Circuit held:

> [The rejection of the "treating physician rule" in the ERISA context by *Black & Decker*] is not to say, however . . . that the SSA determination is meaningless and should be entirely disregarded.

> While it is true that the SSA must apply the "treating physician rule" in its determinations, that rule provides that deference is to be given to the opinions of treating physicians (over those of non-treating or reviewing physicians) where, *and only where*, there is objective support for those opinions in the record . . . . Hence, the SSA determination, though certainly not binding, is far from meaningless. As the Court said in *Black & Decker*, a plan administrator may not arbitrarily disregard the medical evidence proffered by the claimant, including the opinions of her treating physicians. 538 U.S. at 834. Here, the SSA determination, at a minimum, provides support for the conclusion that an administrative agency charged with examining [a beneficiary's] medical records found, as it expressly said it did, objective support for [a treating physician's] opinion in those records.

Id. at 294 (emphasis in original).[6]

Under the facts of this case and the relevant statutory and case law, Metlife can hardly call the SSA's decision finding Ms. Glenn disabled "[un]reliable" evidence that it can "arbitrarily refuse to credit." *Black & Decker*, 538 U.S. at 833-834. To do so borders on the type of "fraud" and "inconsistency" the *Ladd* approach is designed to prevent. The arbitrariness of Metlife's flip-flopping and the sensibility of the *Ladd* rule becomes even more poignant given that an ERISA fiduciary acts in a

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[6] Petitioners cite *Whitaker*, Pet. 17 n.6, a Sixth Circuit case decided before *Calvert*, which implied in dicta that *Ladd* is no longer viable after this Court's rejection of the treating physician rule in *Black & Decker*. *Whitaker*, 404 F.3d at 949. As noted in the text above, *Calvert* implicitly (and correctly) rejected this reasoning, since the rationale of *Ladd* applies regardless of the treating physician rule's applicability. *See Ladd*, 148 F.3d at 154-156. *See also Darland*, 317 F.3d at 528-30 (adopting the *Ladd* approach independent of the treating physician rule).

relationship of "trust," and is subject to a duty of loyalty, 29 U.S.C. § 1104(a)(1)(A), and a duty of care, *id.* § 1104(a)(1)(B). *See generally Firestone*, 489 U.S. at 110-11, 115. Although not a named party in the SSA proceedings, for all practical purposes, and in view of both ERISA statutory provisions and Metlife's plan at issue, Metlife could not "arbitrarily refuse to credit" the SSA decision.[7] As such, the Sixth Circuit's consideration of Metlife's failure to do so—and merely as one *non-determinative* factor in its review—was fully justified.

In sum, there is no split of authority under the facts of this case concerning whether Metlife was required to at least consider, no less refute, the SSA's decision finding Ms. Glenn disabled. Furthermore, the holdings of the circuit courts on this issue not only remain sound law after, but are further reinforced by, this Court's decision in *Black & Decker*.

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[7] Metlife contends that the "only evidence before" Metlife "was the [SSA] decision" but not the "underlying testimony and exhibits . . ." and that "the administrator did not know what underlying testimony or medical records were presented in the SSA case." Pet. 16, 23. As noted above, by way of Kennedy & Associates, Metlife actually contributed exhibits to the SSA record. J.A. 339, 356. Indeed, when deciding Ms. Glenn's appeal in March 2003, Metlife requested that Kennedy & Associates "send[] back [a] copy of [the] file sent by Met[life] to them," which was quickly faxed to Metlife for consideration. A.R. 49. Additionally, the administrative record contains a detailed brief by Kennedy & Associates, setting forth the facts and arguments in favor of a finding of "disability." J.A. 341-347. In any event—even if, *arguendo*, the SSA decision were the "only" SSA evidence in the record—Metlife makes no argument that it was too "unreliable" to be considered.

II. Because of Metlife's Actual Conflict of Interest Due to its Retention of Counsel for Ms. Glenn as well as Other Irregularities in its Review Process, No Split of Authority is Implicated in this Case Regarding Metlife's Status as a Dual-Role Insurer

This Court's decision in *Firestone* states in dicta, that if a "benefit plan" subject to ERISA "gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion'" by the administrator. 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

Since *Firestone*, the courts of appeals have taken different approaches on whether the denial of benefits by dual-role insurers (i.e., those that both grant and pay benefits) inherently involves a conflict to be considered in judicial review. The majority of the circuits addressing the issue, including the Third, Fourth, Fifth, Sixth, Eighth, Ninth, Tenth, and Eleventh circuits, have essentially held that a dual-role insurer is subject to an inherent conflict to be considered in judicial review. *See* Pet. 8-9 (citing cases). In contrast, the First, Second, and Seventh Circuits have basically held that there is no inherent conflict of a dual-role insurer that should be considered. These circuits require an additional evidentiary showing beyond the dual-role relationship itself for the conflict to be considered. *Mers v. Marriott International Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020-21 (7th Cir. 1998); *Doyle v. Paul Revere Life Insurance Co.*, 144 F.3d 181, 184 (1st Cir. 1998); *Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475, 477-78 (2d Cir. 1997) (citing *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 440-44 (2d Cir. 1995)).

Like the Petitioners' misconstrual of the split of authority regarding Metlife's failure to consider the SSA decision, no split of authority is implicated in this case on the dual-role, status-based "conflict of interest" issue, because there is significant *additional evidence* of an *actual* conflict in this case. Specifically, Metlife compromised its duty of loyalty to Ms. Glenn by its financially motivated behavior before and after the SSA proceedings. Before the proceedings, Metlife "retained [counsel] to represent [her] before the Social Security Administration," assisted her by introducing evidence to the SSA, and financially benefited from the vigorous arguments of counsel in front of the SSA. *See* Pet. App. 4a, 11a, 21a; *supra* pp. 6-7. Under the *Ladd* rationale, Metlife was at that point nearly wedded to the arguments Kennedy & Associates made in front of the SSA. However, after the SSA decision issued and Metlife was reimbursed, it refused to consider the SSA decision in terminating Ms. Glenn's benefits, strongly evidencing a financial conflict of interest. As the Sixth Circuit found:

> Metlife's decision to deny long-term benefits in this case was not the product of a principled and deliberative reasoning process. Metlife acted under a conflict of interest and also in unacknowledged conflict with the determination of disability by the Social Security Administration.

Id. at 25a.

These facts would present a sufficient basis under the law of the First, Second, or Seventh Circuits to implicate review of Metlife's conflict of interest. For example, in *Hess v. Reg-Ellen Mach*, 423 F.3d 653, 660 (7th Cir. 2005), the Seventh Circuit reiterated its test that for the court to consider a conflict, a claimant must provide "specific evidence of actual bias that there is a significant conflict." In *Hess*, evidence showed that granting benefits "would impact [the administrator's] operating results," which the

court found sufficient to consider the conflict. *Id.* at 660. In *Pagan*, the Second Circuit held that a conflict will be considered where the claimant "explain[s] how such an alleged conflict affected the reasonableness of the Committee's decision." 52 F.3d at 443. Similarly, in *Doyle*, the First Circuit stressed that "the burden [is] on the claimant to show that the [insurer's] decision was improperly motivated" by the conflict of interest. 144 F.3d at 184.

Here, there is strong evidence that Metlife's behavior was significantly influenced by its self-interested financial motives. Specifically, when it was in Metlife's financial interest to label Ms. Glenn "disabled," it retained counsel and supplied evidence in order to further her claim to SSA benefits; conversely, when it was Metlife's interest *not* to label Ms. Glenn "disabled," it ignored evidence in order to terminate her claim to plan benefits. Because of the arbitrary nature of such a reversal—including Metlife's failure to consider, no less refute, the SSA decision and reliable evidence from Ms. Glenn's treating physician—and the direct impact of these actions on Metlife's bottom line,[8] there is both ample "evidence of actual bias that there is a significant conflict" and a coherent "explanation [of] how [Metlife's]

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[8] Because of the favorable SSA decision and the 100% offset of plan benefits by SSA benefits, Metlife was able to reduce its monthly payment from $1850 first to, $1025, and later to, $991. A.R. 73. If Metlife had continued paying Ms. Glenn's benefits until age 65, specifically, December 11, 2017, A.R. 87, as required by the plan, A.R. 7, this reduction in payment from the SSA benefits offset would have saved Metlife approximately $175,000. Terminating Ms. Glenn's remaining plan benefits saved Metlife about another $180,000. A.R. 7, 73. Although one could retort that the financial impact of terminating benefits here is not of great magnitude, $355,000 is no paltry sum. Moreover, such amounts add up quickly over many claimants; presumably, it is no coincidence that Metlife exhibited similarly conflicted behavior in *Ladd*.

alleged conflict affected the reasonableness" of its decision.

Thus, this case does not depend on the split among the circuits regarding mere status-based, "dual-role" conflicts of interest. Moreover, it fully applies this court's rule in *Firestone* that if "an administrator . . . is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion'" by the administrator. 489 U.S. at 115.[9]

III. Metlife's Actions Were "Arbitrary and Capricious" Regardless of Whether it Acted Under a "Conflict of Interest" or Failed to Consider the SSA Decision

Irrespective of Metlife's dual-role conflict of interest and its failure to consider the SSA decision, the Sixth Circuit properly held that Metlife acted in an "arbitrary and capricious" manner by its categorical refusal to consider reliable evidence of Ms. Glenn's treating physician. Thus, consideration of either question presented is not determinative of the outcome in this case.

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[9] Even if there were no actual conflict of interest present in this case, the Sixth Circuit's approach to dual-role conflicts aligns with the overwhelming number of judges who have addressed this issue in a precedential context. Indeed, in the only courts deciding the issue en banc, both adopted the majority view in unanimous or near unanimous fashion. *See Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006) (en banc) (13 judges holding that a mere dual-role conflict should be considered in judicial review with two judges concurring in the judgment on other grounds); *Vega v. National Life Services*, 188 F.3d 287 (5th Cir. 1999) (en banc) (holding same 16-0). As these cases illustrate, the circuit courts have been addressing this issue en banc and, in cases such as *Abatie*, conforming inconsistent case law to the majority approach. If this Court were inclined to review this split—which is not at issue here—prudence would advise doing so from a circuit with the increasingly disfavored minority view.

In particular, the Sixth Circuit held that:

> Even more perplexing than [Metlife's] failure to consider the award of Social Security benefits is the persistent failure to give any weight to Dr. Patel's letters of July 22, 2002, and February 12, 2003, in which he clearly stated that he did not believe [Ms.] Glenn was capable of returning to work, sedentary or otherwise. This omission stands in stark contrast to the heavy reliance Metlife placed in its brief on the "physical capacity assessment" form that Metlife provided to Dr. Patel and that he filled in and signed on March 13, 2002. . . . The omission is critical, because the failure to consider evidence that is offered after an initial denial of benefits renders a final denial of benefits arbitrary and capricious. . . . We conclude that the plan administrator's rejection of Dr. Patel's assessment, under the standard set out in the plan, was in fact arbitrary.

Pet App. 15a-22a.

The Sixth Circuit's holding that Metlife's actions were "arbitrary and capricious" independent of its refusal to consider the SSA opinion and its dual-role conflict of interest, correctly applies ERISA and this Court's jurisprudence. As noted above, in *Black & Decker Disability Plan v. Nord*, this Court recognized that ERISA "require[s] '*full and fair*' assessment of claims . . . ." 538 U.S. at 825 (citing 29 U.S.C. § 1133) (emphasis added). Additionally, this Court held that "[p]lan administrators . . . may not arbitrarily refuse to credit a claimant's *reliable* evidence . . . ." 538 U.S. at 833-834 (emphasis added). Finally, the plan clearly states that Metlife "will re-evaluate *all the information*" in its files upon a request for review following a denial of claims. A.R. 23-24 (emphasis added). Metlife met none of these requirements, resulting in a decision that was "arbitrary and capricious" solely on this basis.

As such, any decision by this Court on either question presented would have no effect on the outcome of this case.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

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No. 06-923

In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY, PETITIONERS

v.

WANDA GLENN

On Petition For A Writ Of Certiorari To The United States Court of Appeals for the Sixth Circuit

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INTRODUCTION

The Opposition casts no doubt on the urgent need for this Court to resolve the two issues presented. Indeed, respondent essentially admits the existence of circuit conflicts on both issues. Her principal argument against *certiorari* is that this case, in her view, does not provide a suitable *vehicle* for resolving those issues because, even if she lost them here, she has additional bases on which she could urge the Court of Appeals to reach the same result. As we demonstrate below, however, those arguments would neither prevent this Court from reaching the issues presented nor undermine the suitability of this case as a vehicle for resolving them.[1]

I. THE OPPOSITION CASTS NO DOUBT ON THE NEED FOR THE COURT TO RESOLVE THE CIRCUIT CONFLICT OVER "DUAL FUNCTION" CONFLICTS OF INTEREST, OR THE SUITABILITY OF THIS CASE AS A VEHICLE FOR DOING SO.

Respondent concedes that there is a conflict among the circuits over whether the fact that an ERISA administrator is also a plan funder creates a conflict of interest. Opp. 21. She also admits that this conflict is wide, deep and mature. As she notes, eight circuits, "the Third, Fourth, Fifth, Sixth, Eighth, Ninth, Tenth and Eleventh Circuits have essentially held that a dual-role insurer is subject to an inherent conflict to be considered on judicial review," while three circuits, "the First, Second, and Seventh Circuits" have basically held that there is no "inherent conflict" arising from the fact that the insurer plays this dual role. Opp. 21.

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[1] There have been further developments in this case that have no bearing on the petition. On September 1, 2006, the Sixth Circuit remanded the case to the United States District Court for the Southern District Of Ohio, Eastern Division. On remand, the District Court ordered Respondent's benefits reinstated retroactively. *Glenn* v. *MetLife*, 2007 U.S. Dist. LEXIS 1421, (S.D. Ohio Jan. 8, 2007). On February 23, 2007, the Sixth Circuit ordered that the mandate be recalled and stayed until this Court dispenses with the petition.

1. Respondent nevertheless argues that this conflict is not really "implicated in this case" because, in Respondent's view, there is sufficient additional evidence to establish a conflict of interest "under the law of the First, Second, or Seventh Circuits." Opp. 22. Respondent's conclusion is incorrect for three reasons.

First, Respondent does not dispute that the Sixth Circuit did not *rely* upon any of her "additional evidence" in finding a conflict of interest. She does not dispute, for example, that the Sixth Circuit, applying settled Circuit law, found what it called a "conflict of interest" *solely* on the basis of MetLife's "dual function" as funder and administrator. Pet. App. 10a. Nor does she dispute that the Sixth Circuit, again applying settled Circuit law, specifically faulted the district court's decision on the ground that it "does not include any discussion of the role that MetLife's conflict of interest may have played in its decision nor appear to give that conflict any weight," and therefore that the district court failed to give "appropriate consideration" to this alleged conflict. Pet. App. 10a.[2]

Respondent's core argument, then, is that the Sixth Circuit *could* have ruled in Respondent's favor if it had applied the law of the First, Second and Seventh Circuits rather than the settled law of the Sixth Circuit. But that obviously does not mean the conflict is not "implicated" by the decision below, much less eliminate the need for this Court to resolve the acknowledged circuit conflict on this important issue. The most it means is that, if this Court grants certiorari and holds that the approach employed by the First, Second, and Seventh Circuits is correct, Respondent may still have an ar-

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[2] Respondent cites no support for her contention that the many circuits that treat the existence of a "dual function" as tantamount to a conflict of interest are subject to the "limiting conditions" that respondent claims, i.e., that the insurer must *also* "categorically refuse to consider reliable evidence of the beneficiary's treating physician as well as an SSA decision finding the beneficiary 'disabled.'" Opp. 14. In fact, none of the cases cited in the petition imposed any such "limiting condition."

gument—on remand unless this Court expands the questions presented—that the *result* reached by the Sixth Circuit was correct. But againthat is no reason why this Court cannot or should not resolve, in this case, the circuit conflict that Respondent herself acknowledges.

Second, Respondent cannot point to any decisions suggesting that the First, Second or Seventh Circuits would find an actual conflict on the basis of the additional facts she cites–*i.e.*, assisting a claimant to obtain social security benefits or declining to consider an SSA decision or evidence from the claimant's treating physician. For example, she cites no case law suggesting that such facts are even considered as *evidence* of a conflict of interest, much less evidence sufficient to show "a *significant* conflict." Opp. 22 (quoting *Hess* v. *Reg-Ellen Mach*, 423 F.3d 653, 660 (7th Cir. 2005)). Indeed, she offers no analysis of any decisions of the First or Second Circuits in support of her argument. And she cites only one Seventh Circuit case, *Hess*, in which the "additional evidence" of a conflict was the fact that the magnitude of the payment at issue was so large in relation to the entity's assets that it "would impact operating results." The Seventh Circuit, however, carefully distinguished that case from others, similar to this one, involving large insurance companies that would *not* be impacted by the magnitude of the payment. In those cases, the Seventh Circuit has held that the dual status of an ERISA administrator such as MetLife has *no* effect on judicial review. See Petition at 7-8 (citing cases).[3]

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[3] The Seventh Circuit, moreover, has refused to find any "actual conflict" based on evidence analogous to that cited by the Respondent here. See, *e.g.*, *Cuddington* v. *Northern Ind. Public Serv. Co.*, 33 F.3d 813, 816 (7th Cir. 1994) ("Just because the Pension Committee is dominated by NIPSCO employees does not automatically mean that a conflict exists."); *Mers* v. *Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998)("We presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict. The existence of a potential conflict is not

Third, there is no logical reason to treat respondents' "other evidence"--again, assisting a claimant to obtain social security benefits or declining to consider an SSA decision or evidence from a claimant's treating physician—as establishing a conflict of interest. If such facts—which at most show that the administrator was looking for reasons to deny the claim—were sufficient to establish a conflict of interest, a claimant would be able to establish such a conflict in virtually every case in which a disagreement arises. Evidence of an inclination or desire to deny a claim will be found in virtually *every* case in which the claimant is disappointed by the administrator's decision. And, as the Seventh Circuit held in *Hess*, it makes no sense to adopt "a heightened standard of review solely because a corporation or insurer interprets its own plan to deny benefits." 423 F.3d at 659.

2. There can be no doubt that this circuit conflict is desperately in need of resolution. In the eighteen years since *Firestone* v. *Bruch*, 489 U.S. 101 (1989), literally hundreds of judges have devoted hundreds of pages discussing the meaning of one sentence in that decision—a sentence that some believe applies to the situation in which the ERISA administrator is also the plan funder: "[o]f course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' Restatement (Second) of Trusts 187, Comment *d* (1959)." *Firestone*, 489 U.S. at 115. As demonstrated in the petition, the circuits have virtually all attempted but failed to settle on a common interpretation of

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enough.")(citation omitted); *Leipzig* v. *AIG Life Ins. Co.*, 362 F.3d 406 (7th Cir. 2004); *Rud* v. *Liberty Life Assurance Co.*, 438 F.3d 772 (7th Cir. 2006); *Davis* v. *Unum Life Ins. Co.*, 444 F.3d 569 (7th Cir. 2006); *Van Boxel* v. *Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1051, 1053 (7th Cir. 1987).

that sentence. Several decisions have urged this Court to resolve the issue.[4]

Resolution of the circuit split is also urgently needed as a matter of simple fairness. As noted in the petition, Congress specifically provided that ERISA administrators could serve in dual capacities. Pet. 10-11. However, as a result of the present circuit conflict, administrators of national benefit plans that are also plan funders face different standards, sometimes even for the *same* benefit decision Depending upon the circuit in which the benefit decision is reviewed, the dual status of an ERISA administrator may have no effect[5], may be considered as evidence of a conflict of interest[6], may change the standard of review[7], may change the burden of proof[8], or may make the administrator's benefit decision presumptively void[9]. Thus, similar benefit decisions are approved in one circuit and overturned in others, solely on the basis of the dual relationship specifically authorized in the statute.

This is no small matter. MetLife alone processes more than 290,000 disability claims per year, and desperately

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[4] *E.g., Mario* v. *P & C Food Mkts.*, 313 F.3d 758, 763 n.3 (2d Cir. 2002) (noting that "[t]he correctness—and wisdom—of the *Firestone* decision . . . has been cogently challenged by the country's leading ERISA scholar); *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F. 3d 377, 383 (3rd Cir. 2000); *Pagan* v. *NYNEX Pension Plan*, 52 F. 3d 438, 442 (2nd Cir. 1995); *Wallace* v. *Reliance Standard Life Ins. Co.*, 318 F. 3d 723, 724 (7th Cir. 2003).

[5] *Wright* v. *R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F. 3d 67, 74-5 (1st Cir. 2005).

[6] *Elliott* v. *Metro. Life Ins. Co.*, 473 F.3d 613, 621 (6th Cir. 2006).

[7] *Carolina Care Plan, Inc.* v. *McKenzie*, 467 F.3d 383, 386 (4th Cir. 2006).

[8] *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006-7 (10th Cir 2004), *cert. denied*, 544 U.S. 1026 (2005)

[9] *Brown* v. *Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990).

needs a resolution of this issue so that it knows how properly to manage its massive benefits business.[10] Other large plans are similarly affected. See, *e.g.*, Brief of American Council of Life Insurers in No. 05-1424, *MetLife* v. *Hawkins-Dean* , at 9-15.

Moreover, as two scholars recently put it, "[t]he fact that different judges . . . ., still disagree about what *Firestone* requires, reinforces the drastic need to clarify and simplify this chaos." Donald Bogan & Benjamin Fu, *No Further Inquiry into a Conflicted Plan Administrator Claim Denials*, 58 Okla. L. Rev. 637, 655 (2005). But because the circuits are entrenched in their positions,[11] only this Court can resolve the conflict. This case provides a good vehicle with which to do so.

II. THE OPPOSITION CASTS NO DOUBT ON THE NEED TO RESOLVE THE CONFLICT OVER AN ERISA ADMINISTRATOR'S DUTY TO ADDRESS IN ITS DECISION AN SSA DISABILITY AWARD, OR THE SUITABILITY OF THIS CASE AS A VEHICLE FOR RESOLVING THAT ISSUE.

Respondent also does not dispute the petitioner's explication (at 16-19) of the circuit conflict as to whether an ERISA administrator must address a contrary SSA award in its written benefit decision. Nor does Respondent dispute the depth or maturity of that conflict, with the Eight, Ninth, and D.C. Circuits holding that an adverse SSA award need not be addressed in an ERISA administrator's benefit decision, and the First, Second and Sixth Circuits holding that such an award

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[10] 2004 U.S. Group Disability Sales and In Force Survey, LIMRA International.

[11] Indeed, the Sixth Circuit recently reiterated its holding in this case that less deferential review applies when an ERISA administrator is also a plan funder. *Elliott* v. *Metro. Life Ins. Co.*, 473 F.3d 613, 621 (6th Cir. 2006) ("In *Glenn*, we observed that 'MetLife is authorized both to decide whether an employee is eligible for benefits and to pay those benefits. This dual function creates an apparent conflict of interest.' MetLife is under the same apparent conflict of interest here as it was in Glenn.") (citation omitted).

must be addressed if the administrator wishes to avoid having its decision second-guessed as arbitrary and capricious.

1. Respondent argues that because MetLife asked Respondent to file an SSA claim, referred her to an SSA attorney and benefited from reimbursement for dual benefits, there is a "penumbra of judicial estoppel" which makes it arbitrary and capricious for the administrator subsequently to deny that the claimant is fully disabled. Opp. 15. Respondent, moreover, agues that MetLife's own participation in the SSA proceeding sufficiently distinguishes this case from those that have held that an administrator need not address a prior SSA decision in a benefits decision under an ERISA plan. Respondent is mistaken for two reasons.

First, contrary to Respondent's argument (at 14), the Sixth Circuit's holding here was not "limited" to the situation in which an administrator "require[d], assist[ed] or encourage[d] a beneficiary to obtain SSA benefits." To the contrary, in its conclusion that the administrator's decision was arbitrary, the decision below treated this assistance as a *separate* "factor" from the bare fact that MetLife had "failed to address Social Security's contrary determination of Glenn's status." Pet. App. 11a. Under the decision, the latter fact could have been a *sufficient* basis for a finding of arbitrariness, without MetLife's participation in the SSA proceeding.

Second, Respondent cites no evidence that any of the other cases cited in the petition on this issue turned on the existence *vel non* of the administrator's participation in the SSA proceedings. Thus, respondent has failed to show that the decision below is fairly distinguishable from other decisions effectively requiring an administrator to address an adverse SSA determination.

2. To the extent the Sixth Circuit agreed with the Seventh Circuit's "judicial estoppel" theory, moreover, that only heightens the need for this Court's review. This Court struck down a similar "presumption of judicial estoppel" regarding the SSA and the Americans with Disabilities Act in *Cleveland*

v. *Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 802 (1999) ("despite the appearance of conflict that arises from the language of the two statutes, the two claims do not inherently conflict to the point where courts should apply a special negative presumption"). As in *Cleveland*, there is no place in this area for judicial estoppel because the standards for disability are different under the Social Security Act and the ERISA plan.

Judicial estoppel is also inappropriate in this case because the medical records on which MetLife relied differed substantially from those present in the SSA appeal.[12] Courts have treated such differences as dispositive. For example, in *Block* v. *Pitney Bowes, Inc.*, 952 F.2d 1450, 1455 (D.C. Cir. 1992), the court stated that "[t]he Social Security award . . . rested at least in part on medical reports never submitted to the Committee. Courts review ERISA-plan benefit decisions on the evidence *presented to* the plan administrators. . . ." (emphasis added).[13]

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[12] Indeed, the Sixth Circuit noted one of the records falling into the former category: "the record before the [SSA] administrative law judge did not include the report, signed on the same day that the administrative judge's decision was made, in which Dr. Patel answered 'yes' to MetLife's question, 'Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?'" Pet. App. 14a. In addition, Respondent admits that, in making its disability decision, the SSA relied on medical records that were never provided by Respondent to MetLife. Opp. 5 For example, in support of her appeal before the SSA, Respondent submitted 23 medical reports, assessments or analyses. (J.A. 338) Of those 23 exhibits to the SSA record, Respondent did not provide 13 of those records to MetLife, including 6 that were specifically referenced or commented upon in the ALJ's final determination that Respondent was totally disabled from any occupation. (J.A. 331-336).

[13] Respondent also argues that MetLife was conflicted because it allegedly did not *consider* the SSA award before making its final decision. However, the record is undisputed that, before its final benefit determination, MetLife was aware of the SSA award, received a copy of the SSA award from Respondent's attorneys (J.A.

In short, Respondent has offered no plausible response to our showing that *certiorari* is warranted on the second issue presented, and that this case is a good vehicle with which to resolve that issue.

III. RESPONDENT'S ARGUMENT THAT THE SIXTH CIRCUIT WOULD HAVE FOUND A CONFLICT OF INTEREST WITHOUT ITS OTHER ERRORS LIKEWISE MISSES THE POINT.

Respondent also argues that the Sixth Circuit would have reached the same result based solely on the contrary medical evidence or on other factors besides those in the two questions presented, and argues that this too counsels against a grant of *certiorari*. Here again, respondent is wrong.

First, as noted, the Sixth Circuit clearly reached holdings on these two questions. As the Circuit stated "we are entitled to take into account the existence of a conflict of interest that results when, as in this case, the plan administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits and to factor in the plan administrator's failure to give consideration to the Social Security Administration's determination that Glenn was totally disabled." Pet. App. 10a. Similarly, the Circuit stated, "the court's analysis of the plan administrator's basis for terminating benefits does not include any discussion of the role that

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167-169, 327), and discussed the SSA award with Respondent on the telephone. J.A. 172. Indeed, respondent specifically asked MetLife to explain the SSA decision, at which time it was explained to her that MetLife reached a different decision because its decision was based on all the information MetLife had received. *Id.* She was told that "if she feels that any information used by the SSA to reach a decision should be part of her appeal, she should include it with her written appeal." *Id.* One week later, Respondent wrote to MetLife appealing the denial of her claim and enclosing some, but not all, records pertaining to the SSA appeal. J.A. 204. The record reflects that MetLife received her letter and considered all information contained in its file, including the SSA decision, before denying her appeal. (J.A. 173-176).

MetLife's conflict of interest may have played in its decision nor appear to give that conflict any weight. It appears to us, as a result, that this factor did not receive appropriate consideration by the district court. . . . There is yet another factor [the SSA award] that the district court appears to have given inadequate consideration." Pet. App. 10a.

Once again, then, Respondent is trying to avoid review of the two questions presented by claiming, in essence, that there is or might be on remand an alternative ground for affirmance. And once again, the fact that there might be such an alternative ground is not relevant to this Court's decision on *certiorari*. It would be relevant, if at all, on remand, *after* a decision by this Court on the merits. The fact that Respondent might be able to argue on remand that the Sixth Circuit reached the right result based on other factors does not prevent this Court from reaching the issues presented. Nor does it lessen the need for review or the suitability of this case as a vehicle for resolving the issues presented.

In summary, there is no question that the present *effect* of the Sixth Circuit's decision and others like it is (a) to discourage companies from playing the very dual-use function that Congress contemplated, and (b) to effectively require them to address SSA determinations if they do not wish to run a serious risk of having their decisions overturned by the courts. Review is needed, therefore, not so much to change the result in this particular case (although that will be the likely result), but to resolve the intolerable conflicts in the law and thereby give administrators better guidance for future cases. This case provides an excellent vehicle with which to do just that.

CONCLUSION

The petition for writ of certiorari should be granted.

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March 2007

No. 06-923

In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY), ET AL., PETITIONERS

v.

WANDA GLENN

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

1. Whether an administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 *et seq.*, is operating under a conflict of interest that must be weighed on judicial review of a benefit determination.

2. Whether an ERISA plan administrator must consider in its written benefit determination a decision of a Social Security Administration administrative law judge granting disability benefits.

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WANDA GLENN

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition should be granted on the first question presented, and the parties should be directed to address a related question. See pp. 11-13, 22, *infra*. The petition should be denied on the second question presented.

STATEMENT

1. The Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 *et seq.*, was enacted to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of [those] plans, and by providing for appro-

priate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b). As part of ERISA's comprehensive enforcement scheme, Section 502(a)(1)(B) authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. 1132(a)(1)(B).

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), this Court considered the appropriate standard of review in an action to recover benefits under an ERISA plan. *Id.* at 108. Noting that Congress did not specify a standard, the Court turned to the purposes of ERISA and its basis in trust law to determine the appropriate standard. *Id.* at 108-115. It concluded "that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case abuse-of-discretion review applies. *Id.* at 115. The Court noted, however, that more searching review is necessary in the case of a conflicted decisionmaker: "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Ibid.* (quoting Restatement (Second) of Trusts § 187 cmt. d at 403 (1959) (Second Restatement)).

2. Respondent worked for Sears, Roebuck and Company (Sears) from 1986 until 2000, when she was diagnosed with a heart condition and took a medical leave of absence. Pet. App. 2a-3a. Respondent then applied for disability benefits under her Sears-sponsored ERISA plan, which was both administered and insured by petitioner MetLife. *Id.* at 2a-3a. MetLife approved respon-

dent's claim for short-term disability benefits. *Id.* at 3a. At MetLife's direction and with the help of counsel retained for her by MetLife, respondent then applied for and received Social Security disability benefits. *Ibid.*

After paying short-term benefits for the maximum term, MetLife notified respondent that she must demonstrate that she qualified for long-term disability benefits, which required her to establish her inability to perform "*any* gainful work" for which she was reasonably qualified. Pet. App. 3a-4a. Respondent submitted medical records from Dr. Rajendera Patel, her treating cardiologist, who ultimately concluded that respondent's heart condition made her unable to "return to any kind of even sedentary work." *Id.* at 4a-7a. MetLife had an independent physician and a vocational rehabilitation coordinator review respondent's file. *Id.* at 30a. It then concluded that the medical records did not support her claim of total disability and terminated her benefits. *Id.* at 7a. Respondent appealed, and MetLife affirmed its denial of disability benefits. *Id.* at 8a.

3. The district court upheld MetLife's denial of benefits. Pet. App. 27a-40a. The court applied an "arbitrary and capricious" standard of review because the plan "grant[ed] the administrator discretionary authority" to determine benefits. *Id.* at 32a-33a. It noted, however, that "an actual conflict of interest exists" because MetLife "both decides whether an employee is eligible for benefits and pays those benefits," and that conflict must be "weigh[ed]" "as a factor" in reviewing the benefits denial. *Id.* at 32a-34a.

The district court then reviewed the medical evidence and concluded that MetLife's decision was not arbitrary and capricious because there was "substantial evidence supporting MetLife's determination that [re-

spondent] was no longer disabled." Pet. App. 37a-40a. In so holding, the court recognized that the administrator had not considered the award of Social Security disability benefits, but the court rejected respondent's contention that the award substantiated her disability, finding that "the records before the ALJ and MetLife were materially different." *Id.* at 36a.

4. The court of appeals reversed and reinstated respondent's benefits. Pet. App. 1a-26a. Like the district court, it applied an "arbitrary and capricious" standard of review because the plan granted the administrator discretionary authority to determine benefits. *Id.* at 9a. The court held, however, that MetLife was operating under an "apparent conflict of interest" because it was "authorized both to decide whether an employee is eligible for benefits and to pay those benefits," and it concluded that the district court failed to give that conflict "appropriate consideration" in reviewing the benefit denial. *Id.* at 10a.

The court of appeals also determined that the district court gave "inadequate consideration" to MetLife's failure to address the award of Social Security disability benefits, particularly in light of the fact that MetLife "had encouraged and assisted [respondent] in obtaining Social Security disability benefits" and "benefitted financially from the government's determination that [respondent] was totally disabled." Pet. App. 10a, 14a-15a. Although that failure "d[id] not render the decision arbitrary *per se*," the court held, it was "a significant factor to be considered upon review." *Id.* at 15a.

After reviewing the medical evidence, the court of appeals held that MetLife's "inappropriately selective consideration of [respondent's] medical record," combined with its conflict of interest and its failure to ad-

dress the Social Security disability benefits award, led to a benefit denial that "can only be described as arbitrary and capricious." Pet. App. 25a.

DISCUSSION

Since *Firestone*, the courts of appeals have struggled with how to review a benefit determination by an ERISA plan administrator that is vested with discretionary authority to interpret plan terms or make benefit determinations and also must pay any claims that it finds to be valid. Clear circuit conflicts have developed on two questions. First, the courts of appeals disagree on whether an administrator that both makes claims determinations and pays benefits should be regarded as operating under a conflict of interest that must be taken into account on judicial review of its benefit determination. Second, the courts of appeals have divided on the closely related question of how to weigh such a conflict of interest, if one is deemed to exist, in reviewing a benefit determination. Both questions were raised throughout this case, both questions were addressed by the court of appeals below, and both questions are of substantial importance. Accordingly, the United States recommends that this Court grant review on the first question presented in the petition, and also direct the parties to address in their briefs the further question of how a court should weigh a conflict of interest in reviewing a dual-role administrator's discretionary benefit determination.

This Court's review is not warranted on the second question presented. The circuits agree that the weight to be given to a Social Security disability determination varies based on the facts of the case, and the Sixth Cir-

cuit reasonably took the award of Social Security benefits into account in the circumstances present here.

A. The Question Whether A Dual-Role Plan Administrator Has A Conflict Of Interest Warrants This Court's Review

1. The decision below conflicts with the decisions of several other courts of appeals on two intertwined and important questions

This Court explained in *Firestone* that, although ERISA benefit determinations generally should be reviewed *de novo*, abuse-of-discretion review applies if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. Under that standard of review, an administrator's exercise of judgment "will not be disturbed if reasonable." *Id.* at 111 (citing George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 559, at 169-171 (2d rev. ed. 1980)); see also Restatement (Third) of Trusts § 87 cmts. b and c at 243-244 (2007) (Third Restatement); Second Restatement § 187 cmt. e at 403 (court will not interfere unless trustee "acts beyond the bounds of a reasonable judgment"). The Court also indicated that more searching review is appropriate when the plan administrator labors under a conflict of interest. 489 U.S. at 115. Since *Firestone*, two questions have arisen with increasing frequency—and divided the courts of appeals—regarding how the courts are to apply that guidance in reviewing benefit determinations made by dual-role administrators that have discretionary authority to interpret plan terms or make benefit determinations.

a. First, there is a circuit split on the threshold question whether "the fact that a claim administrator of an ERISA plan also funds the plan benefits, without more, constitutes a 'conflict of interest' which must be weighed in a judicial review of the administrator's benefit determination." Pet. i. The Sixth Circuit in this case held that it does. Pet. App. 10a. The Sixth Circuit explained the basis for that approach in a prior decision, reasoning that a plan administrator that both funds and administers the plan has a financial incentive to deny benefits because it "incurs a direct expense as a result of the allowance of benefits," and it "benefits directly from the denial or discontinuation of benefits." *Killian* v. *Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (1998).

The Third, Fourth, Fifth, Ninth, Tenth, and Eleventh Circuits have agreed that a plan administrator that also pays plan benefits operates under a conflict of interest that must be taken into account on judicial review of a benefit determination. See, *e.g.*, *Post* v. *Hartford Ins. Co.*, 501 F.3d 154, 161-164 (3d Cir. 2007)[1]; *Carolina Care Plan Inc.* v. *McKenzie*, 467 F.3d 383, 386-387 (4th Cir. 2006), cert. dismissed, Nos. 06-1182 & 06-1436 (July 30, 2007); *Vega* v. *National Life Ins. Servs., Inc.*, 188 F.3d 287, 295-296 (5th Cir. 1999) (en banc); *Abatie* v. *Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-966 (9th Cir. 2006) (en banc); *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (10th Cir. 2004), cert. denied, 544 U.S. 1026 (2005); *Brown* v. *Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561, 1566-1567 (11th Cir. 1990), cert. denied, 498 U.S. 1040 (1991).

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[1] The Third Circuit has suggested, however, that there is no conflict of interest when an employer "both funds and administers the plan, but pays benefits out of a fully funded and segregated ERISA trust fund rather than its operating budget." *Post*, 501 F.3d at 164 n.6.

The First and Seventh Circuits have come to the contrary conclusion, holding that the mere fact that a plan administrator also pays claims does not present a conflict of interest that must be taken into account on review of a discretionary benefit determination. See, *e.g.*, *Wright* v. *R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Perlman* v. *Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999). Those courts have reasoned that although there is a *potential* conflict of interest in such circumstances, there is no need to adjust the level of scrutiny because market forces will counterbalance that potential. See, *e.g.*, *Perlman*, 195 F.3d at 981 (explaining that "the award in any one case will have only a trivial effect on [the administrator's] operating results," and plan administrators "want to maintain a reputation for fair dealing with" plan beneficiaries).

The Second Circuit appears to take the same view, holding that the mere fact of a plan administrator's dual roles does not "trigger stricter review" unless the plaintiff shows that "the administrator was *in fact* influenced by the conflict of interest." *Pulvers* v. *First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2000) (quoting *Sullivan* v. *LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255-1256 (2d Cir. 1996)). The Eighth Circuit's approach is similar, requiring, as a condition for heightened review, "material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." *Woo* v. *Deluxe Corp.*, 144 F.3d 1157, 1160-1161 & n.2 (1998). The decision below, which follows the majority approach, thus squarely conflicts with decisions of the First and Seventh Circuits and appears to be in significant tension

with decisions of the Second and Eighth Circuits. In all events, the circuits are clearly in disarray on the issue.

b. The courts of appeals also have divided on the closely related question of *how* a conflict of interest should be weighed on review of a plan administrator's discretionary benefit denial. They have adopted essentially three approaches: abuse-of-discretion review on a "sliding scale," *de novo* review, and burden-shifting.

The first approach, followed by the great majority of courts of appeals and utilized in the decision below, applies abuse-of-discretion review on something of a "sliding scale," whereby the plan administrator's decision is reviewed for reasonableness, and the particular degree of deference afforded depends on the seriousness of the conflict. The Third, Fourth, Fifth, Sixth, and Ninth Circuits utilize variations of this approach. See, *e.g.*, *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Doe* v. *Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Vega*, 188 F.3d at 297; *Borda* v. *Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1065-1069 (6th Cir. 1998) (applying abuse-of-discretion review that is "shaped by the circumstances of the inherent conflict of interest" but not calling it a "sliding scale" (internal quotation marks omitted)); *Abatie*, 458 F.3d at 967 (rejecting the "sliding scale" metaphor but adopting an approach that "is substantially similar to" the sliding-scale approach). In addition, although they do not view an administrator's dual roles alone as a conflict of interest, in circumstances where they do identify a conflict of interest, the First, Seventh, and Eighth Circuits increase the degree of scrutiny of a benefit denial using essentially the sliding-scale approach. See, *e.g.*, *Wright*, 402 F.3d at 74-75; *Mers* v. *Marriott Int'l Group Accidental Death & Dis-*

memberment Plan, 144 F.3d 1014, 1020-1021 & n.1 (7th Cir.), cert. denied, 525 U.S. 947 (1998); *Woo*, 144 F.3d at 1162.[2]

The Second Circuit follows an entirely different approach. Although it does not engage in heightened scrutiny based on an administrator's dual roles alone, when a claimant provides evidence that a potential conflict of interest exists and "'the administrator was *in fact* influenced by the conflict of interest,'" the court utilizes *de novo* review. *Pulvers*, 210 F.3d at 92 (quoting *Sullivan*, 82 F.3d at 1255-1256).

Finally, both the Tenth and Eleventh Circuits utilize burden-shifting approaches. In the face of a conflict of interest, the Tenth Circuit shifts the burden of proof to the plan administrator to establish "the reasonableness of its decision pursuant to [the] court's traditional arbitrary and capricious standard." *Fought*, 379 F.3d at 1006. Under that approach, the "administrator must demonstrate that its interpretation of the terms of the plan is reasonable and that its application of those terms to the claimant is supported by substantial evidence." *Ibid.* Under the Eleventh Circuit's approach, a reviewing court first determines, *de novo*, whether or not the denial of benefits was "wrong." *Brown*, 898 F.2d at 1566. If the benefit denial was correct, the administrator's decision is affirmed; if it was wrong, "the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Ibid.* If the administrator meets that burden, abuse-of-discretion review applies.

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[2] The Eighth Circuit applies a *de novo* standard in "egregious circumstances," but otherwise applies abuse-of-discretion review that is adjusted to account for the seriousness of the conflict. See *Woo*, 144 F.3d at 1161-1162.

See *HCA Health Servs. of Ga., Inc.* v. *Employers Health Ins. Co.*, 240 F.3d 982, 993-995 (11th Cir. 2001). If the administrator does not meet that burden, the court reverses the administrator's decision, having already determined on *de novo* review that it was erroneous. *Ibid.*

Because the Sixth Circuit in this case reviewed respondent's claim under abuse-of-discretion review, tempered by the particular factors warranting increased scrutiny here, Pet. App. 9a-10a, the decision below conflicts with decisions of the Second, Tenth, and Eleventh Circuits, thereby exacerbating an existing circuit split.

c. Certiorari is warranted on both questions that have divided the lower courts in order to provide guidance on when and how a reviewing court should account for a plan administrator's dual roles in both making benefit determinations and paying any benefits due. Since *Firestone*, a growing number of ERISA plans have granted dual-role administrators discretionary authority to determine benefits or interpret plan terms, and the entrenched disagreements in the courts of appeals have caused confusion and disuniformity, as some of the courts of appeals have acknowledged. See, *e.g.*, *Fought*, 379 F.3d at 1004 ("Our failure to articulate clearly the requirements of a less deferential arbitrary and capricious standard has left district courts in this circuit without direction and has encouraged litigation."); *Vega*, 188 F.3d at 296 ("Other Circuits have also struggled with the role a conflict of interest should play in determining whether an administrator has abused its discretion."). Indeed, one noted treatise has deemed "how trial courts are to consider the presence of a conflict of interest on the part of the administrator" "[p]erhaps the biggest question after *Firestone*." Jayne E. Zanglein & Susan J. Stabile, *ERISA Litigation* 507 (2d ed. 2005).

If this Court grants review, the Court should address not only *whether* a dual-role administrator has a conflict of interest, but also *how* a conflict of interest is to be weighed on judicial review of a benefit denial under a plan that grants the administrator discretionary authority to interpret plan terms or decide benefit claims. Those two issues are integrally related. It is, in fact, the latter question that has most "bedeviled the federal courts," *Pinto*, 214 F.3d at 378, and that question is fairly raised here. The latter question has salience in every circuit, because even the circuits that do not view a plan administrator's dual roles standing alone as a conflict of interest still must address how to adjust the standard of review in cases in which they identify a conflict of interest. See pp. 7-10, *supra*. Moreover, this Court itself has recognized the importance of the question of how reviewing courts should account for a conflict of interest in light of *Firestone*. See *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 384 n.15 (2002).

This case provides a suitable vehicle to address both questions, because the court below both found that MetLife operates under a conflict of interest and weighed that conflict in reviewing MetLife's benefit determination. See Pet. App. 9a-10a, 24a-26a. Moreover, because the decision below was correct (in the view of the United States) to identify a conflict of interest, see pp. 13-15, *infra*, the case presents an opportunity to resolve both issues. Respondent suggests that review is unwarranted because the court of appeals would have found that MetLife abused its discretion regardless of its conflict. Br. in Opp. 24. But the court of appeals did not hold that MetLife abused its discretion independent of the conflict; it instead found that the administrator's review of the medical evidence, its failure to address the Social Secu-

rity decision, and its conflict of interest, "*[t]aken together* * * * reflect a decision by MetLife that can only be described as arbitrary and capricious." Pet. App. 25a (emphasis added).

2. MetLife's dual roles in deciding benefit claims and paying benefits is a factor to be weighed in determining the reasonableness of the benefit denial

The Sixth Circuit correctly held that a plan administrator's dual roles as an administrator and insurer of benefits creates a conflict of interest that must be weighed as a factor in reviewing MetLife's benefit denial under *Firestone*.

a. "ERISA abounds with the language and terminology of trust law," *Firestone*, 489 U.S. at 110, and trust law principles counsel that the financial self-interest created when a plan administrator both decides claims and pays benefits should be taken into account by a court in reviewing a denial of benefits under the plan. When "discretion is conferred upon" a fiduciary "with respect to the exercise of a power," its exercise is subject to review for "an abuse * * * of his discretion," which calls for a court to determine whether the administrator's interpretation of the plan and findings concerning eligibility are reasonable. Second Restatement § 187 and cmt. d at 402-403; see p. 6, *supra*. One factor relevant under that test is "the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries." Second Restatement § 187 and cmt. d at 402-403.

In the case of a dual-role administrator, "every exercise of discretion impacts [the administrator] financially, filling or depleting its coffers." *McGraw* v. *Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1259 (10th Cir. 1998). That type of conflict generally warrants careful scrutiny

in the trust context, even in the absence of evidence that the plan administrator actually acted because of its financial self-interest. See, *e.g.*, Third Restatement § 37 cmt. f(1) at 137 (2003) (where a conflict of interests exists, "the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny"); *id.* § 50 cmt. b at 261 (beneficiary who is also trustee may have a permissible "conflict of interest, but his acts are to be carefully scrutinized for abuse"); Second Restatement § 107 cmt. f at 236 (remainderman of a trust who is also the trustee and thus must decide how much to pay to the beneficiary operates under a conflict of interest); 2A Austin W. Scott & William F. Fratcher, *The Law of Trusts* § 170.23A at 429 (4th ed. 1987) (bank with both a trust department and a commercial department has "the possibility of conflicts of interest" that should be "considered in determining whether the bank acted for the best interest of the beneficiaries"). Indeed, this Court appears to have recognized as much in *Firestone*, when it stated that a conflict of interest should be "weighed as a 'facto[r]'" in deciding whether a plan administrator has abused its discretion. 489 U.S. at 115 (quoting Second Restatement § 187 cmt. d at 403).

Further, the rule that a plan administrator's financial self-interest must be taken into account on review of benefit determinations is based on the common-sense notion that "[a] conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." *Brown*, 898 F.2d at 1565; see also George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 543, at 227 (rev. 2d ed. 1993). And such a rule best comports with ERISA's broad purpose of "protect[ing] contractually defined benefits." *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985).

Although ERISA permits plan funders to serve as claims administrators, see 29 U.S.C. 1102(c), 1108(c)(3), that authorization does not preclude an appropriately searching review of those administrators' decisions, for Congress left to the federal courts (guided by principles of trust law) the question of how they are to review a dual-role administrator's decisions. See *Firestone*, 489 U.S. 110-111.

b. This Court in *Firestone* also established the basic framework for *how* a conflict of interest should be taken into account on judicial review. ERISA generally permits employers, like settlors in trust law, to set up plans as they see fit, within the general parameters of the Act, see, *e.g.*, *Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432, 444 (1999), and it permits them to grant discretion to plan administrators to interpret plan terms and determine claimants' eligibility for benefits, see *Firestone*, 489 U.S. at 115; 29 U.S.C. 1108(c)(3). ERISA also permits an employer to establish a welfare benefit plan "through the purchase of insurance." 29 U.S.C. 1002(1). A plan sponsor thus could reasonably choose to give discretionary authority for claims administration to an insurance company, notwithstanding its conflict of interest as the ultimate payor of benefits, in light of the cost of alternative arrangements, the insurer's expertise in administering and resolving claims, and the insurance company's past claims history. Where the sponsor has expressly chosen to give the insurer discretion to interpret plan terms or determine eligibility for benefits, review of those decisions applying the abuse-of-discretion standard—under which the decisions "will not be disturbed if reasonable," *Firestone*, 489 U.S. at 111—is the logical starting point because it best comports with the contractual and trust-law underpinnings of ERISA. See *id.* at 110-115.

At the same time, ERISA mandates that a fiduciary "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries," 29 U.S.C. 1104(a)(1), which incorporates the traditional duty of loyalty of a trustee, see Third Restatement § 79, at 127 (2007). Accordingly, the very principles of trust law that call for review of discretionary decisions under a general standard of reasonableness also counsel that a plan administrator's conflict of interest must be weighed as a factor under that standard, as this Court also recognized in *Firestone*. 489 U.S. at 115.

Because the Court in *Firestone* declined to rest its general rule of *de novo* review on the existence of an underlying conflict of interest, 489 U.S. at 115, *de novo* review should not be required where the plan vests discretionary authority in an administrator that also pays benefits. Rather, the existence and nature of a conflict of interest should be taken into account as *part of* traditional review for reasonableness, triggering more careful scrutiny to the degree that the circumstances warrant.

For example, the existence of a conflict of interest should cause a reviewing court to give added scrutiny when an administrator: (1) "provides inconsistent reasons for [the benefit] denial"; (2) "fails adequately to investigate a claim or ask the plaintiff for necessary evidence"; (3) "fails to credit a claimant's reliable evidence"; or (4) "has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record." *Abatie*, 458 F.3d at 968-969. In addition, concern would be raised if there is evidence suggesting that the administrator denied the claimant full and fair review of his claim, as guaranteed by statute and by the Department of Labor's claims regulations, see 29 U.S.C.

1133(2); 29 C.F.R. 2560.503-1(g), (h), and (j), although such a defect might constitute an independent ground for setting aside an administrator's decision. Also, an administrator, facing closer scrutiny, might find it advisable to demonstrate that it has taken measures to mitigate conflict concerns, through the use of truly independent medical examiners or by ensuring that its claims reviewers do not have incentives to deny claims. See *Abatie*, 458 F.3d at 969 & n.7.

This flexible case-by-case approach is most consistent with the Restatement of Trusts and pre-ERISA cases reviewing decisions by conflicted trustees who were acting under express grants of discretionary authority by the trust settlors. See, *e.g.*, *In re Peabody's Will*, 96 N.Y.S.2d 556, 561 (Sup. Ct.), aff'd, 98 N.Y.S.2d 614 (App. Div. 1950). Moreover, this approach best balances ERISA's requirements of fiduciary loyalty, 29 U.S.C. 1104(a)(1), and "full and fair" review of benefit claims, 29 U.S.C. 1133(2); see 29 C.F.R. 2560.503-1(g), (h), and (j), with the statutory authorization for fiduciaries to serve in dual roles, 29 U.S.C. 1108(c)(3), and for employers generally to set up plans as they see fit. The standard neither assumes that every fiduciary administrator with a conflict of interest resolves disputes in a biased manner, nor uncritically defers to the administrator's judgment as if the conflict did not exist. Review under a general standard of reasonableness simply requires that the reviewing court be as skeptical of the administrator's decision as the facts warrant. See *Woo*, 144 F.3d at 1161.

B. The Question Concerning A Plan Administrator's Consideration Of A Social Security Disability Award Does Not Warrant This Court's Review

Certiorari is not warranted to consider how a plan administrator should consider an award of disability benefits by the Social Security Administration (SSA) in its benefit decision. There is no split in legal authority on that question, and the decision below appropriately took that award into account in the circumstances of this case.

1. Contrary to petitioners' contention (Pet. 16), the decision below does not hold that an ERISA plan administrator "must" in all cases consider and refute a "bare" SSA disability determination. Pet. 16. Instead, the court concluded only that SSA's decision finding respondent disabled was a "relevant" factor that MetLife should have addressed in the particular circumstances of this case. Pet. App. 11a. And the decisions petitioners cite (Pet. 19) from the First and Second Circuits also do not hold that a plan administrator must *always* consider a bare SSA determination. See *Pari-Fasano* v. *ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 420 (1st Cir. 2000) (a "Social Security benefits decision *might be relevant* to an insurer's eligibility determination" (emphasis added)); *Paese* v. *Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 442 (2d Cir. 2006) (the district court "acted *well within its discretion*" in "*consider[ing]* the SSA's findings as some evidence of total disability" (emphases added)).

Although petitioners contend that several courts of appeals have rendered decisions in conflict with the decision below (Pet. 17-19), none of those decisions holds that "a bare decision by the Social Security Administration has *no* evidentiary value." Pet. 17. One case, *Conley* v.

Pitney Bowes, 176 F.3d 1044 (8th Cir. 1999), cert. denied, 528 U.S. 1136 (2000), simply stands for the unremarkable proposition that a plan is not *required* to "award benefits to any claimant who is receiving social security benefits." *Id.* at 1050. In another case, *Donato* v. *Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994), overruled on other grounds by *Diaz* v. *Prudential Ins. Co. of Am.*, 424 F.3d 635 (7th Cir. 2005), the Seventh Circuit declined to deem a failure to consider the "medical evidence contained in th[e] [Social Security] file" an abuse of discretion when that supporting evidence was not presented to the plan administrator, *id.* at 380; it did not come to any conclusion with respect to the SSA award itself. The remaining cited decisions represent fact-specific determinations that a plan administrator did not err in failing to give weight to an SSA award in a particular case.[3] Overall, the courts of appeals generally take a flexible approach to the question whether a plan administrator should have considered an SSA determination in a given case, as one would expect based on the fact-specific nature of that inquiry, and there is no legal disagreement that warrants this Court's review.

Indeed, the only other court to have considered the relevance of an SSA determination in circumstances substantially similar to those here took the same approach as the decision below. In *Ladd* v. *ITT Corp*, 148 F.3d 753 (7th Cir. 1998), as in this case, the plan administrator "encouraged and supported [the participant's] effort to

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[3] See *Madden* v. *ITT Long Term Disability Plan*, 914 F.2d 1279, 1285 (9th Cir. 1990) ("all medical evidence submitted to [the plan administrator]" supported a finding of no disability), cert. denied, 498 U.S. 1087 (1991); *Block* v. *Pitney Bowes, Inc.*, 952 F.2d 1450, 1455 (D.C. Cir. 1992) (SSA award was made four years after plan administrator's decision, on a materially different record).

demonstrate total disability to the Social Security Administration, going so far as to provide her with legal representation," then, contrary to SSA's determination and without even mentioning that determination, found that the participant was not disabled. *Id.* at 756. In the Seventh Circuit's view, the plan administrator's failure to consider the SSA determination, though not enough to "provide an independent basis" for reversal, "cast[] additional doubt on the adequacy of [the administrator's] evaluation" of the claim. *Ibid.* The Sixth Circuit cited and applied that approach in the decision below. See Pet. App. 12a-13a (citing *Ladd*, 148 F.3d at 755-756); see also *Darland* v. *Fortis Benefits Ins. Co.*, 317 F.3d 516, 530 (6th Cir. 2003) (applying *Ladd* in similar circumstances), overruled on other grounds by *Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822 (2003).[4] Thus, there is no disagreement as to the significance of an SSA determination in the narrow circumstances present here.

2. The Sixth Circuit reasonably took into account the Social Security disability award under the circumstances of this case. It did not hold that MetLife's failure to consider the award after helping respondent procure it rendered its ultimate decision "arbitrary *per se*"; instead, it found that because the award was based on a finding that respondent was totally disabled, MetLife should have considered the award when it evaluated respondent's condition. Pet. App. 14a-15a. The SSA determination

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[4] Petitioners' claim (Pet. 18) that the decision below conflicts with *Conley* v. *Pitney-Bowes*, 176 F.3d 1044 (8th Cir. 1999), is incorrect, because the court of appeals in that case considered materially different circumstances from this case. See *id.* at 1050 (declining to apply the *Ladd* principle because, among other things, the administrator "did not help [the participant] make his case to the Social Security Administration").

was plainly relevant because the Social Security standard was more stringent than the plan's definition of disability, *id.* at 13a & n.1, and respondent's condition remained essentially unchanged from the time of the SSA award to the time of MetLife's denial of benefits, *id.* at 3a-8a.

Moreover, the Sixth Circuit's approach is consistent with this Court's teaching that "[p]lan administrators * * * may not arbitrarily refuse to credit a claimant's reliable evidence." *Nord*, 538 U.S. at 834. And it is also consistent with the requirement that an ERISA plan provide for a "full and fair review" of a denial of a claim for benefits, 29 U.S.C. 1133(2), which "takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim," 29 C.F.R. 2560.503-1(h)(2)(iv); see 29 C.F.R. 2560.503-1(g)(1)(i) and (j)(1). Indeed, the plan document at issue in this case expressly provided that MetLife "will reevaluate *all the information*" in its files upon a request for review of a claim denial. Br. in Opp. 18 (quoting A.R. 23-24)).

There is, therefore, no reason to grant certiorari on the second question presented and dedicate substantial briefing to it as a stand-alone issue. Nonetheless, the briefing on the first two questions, and any application of the correct legal standard to this case, may involve discussion of the treatment of the SSA award as part of the reasonableness analysis. Thus, limiting the questions to the first question presented and the additional question suggested by the United States will focus the briefing on the questions that have divided the courts of appeals, without foreclosing discussion of the SSA award altogether.

CONCLUSION

The petition for a writ of certiorari should be granted on the first question presented, and the Court should also direct the parties to address the following related question: "If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?" Certiorari should be denied on the second question presented.

Respectfully submitted.

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IN THE
Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED JANUARY 3, 2007
CERTIORARI GRANTED JANUARY 18, 2008

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General Docket
United States Court of Appeals for the Sixth Circuit

Court of Appeals Docket #: 05-3918
Nsuit: 1890 Other Statutory Actions
Glenn v. MetLife, et al.
Appeal From: Southern District of Ohio at Columbus

Filed: 07/20/2005
Termed: 09/01/2006

Case Type Information:
1) Civil
2) Private
3) Federal Question

Originating Court Information:
District: 0648-2 : 03-00572
Trial Judge: George C. Smith, U.S. District Judge
Date Filed: 06/23/2003
Date Order/Judgment: 06/08/2005

Date NOA Filed: 07/07/2005

* * *

WANDA GLENN

Plaintiff – Appellant

v.

METROPOLITAN LIFE INSURANCE COMPANY, et al.

Defendants – Appellees.

07/20/2005	Civil Case Docketed. Notice filed by Appellant Wanda Glenn. Transcript needed: n.
	* * *
08/17/2005	TRANSCRIPT ORDER FORM filed by Stanley L. Myers for Appellant Wanda Glenn: No hearings held in District Court. [05-3918] [3218029-1]
	* * *
09/27/2005	PROOF BRIEF filed by Stanley L. Myers for Appellant Wanda Glenn. Certificate of service date 9/26/05 Number of Pages: 45. [05-3918]
	* * *
11/02/2005	PROOF BRIEF filed by Charles S. Lanz for Appellee MetLife. Certificate of service date 10/31/05. Number of Pages: 46. [05-3918]

* * *

11/18/2005 PROOF REPLY BRIEF filed by Stanley L. Myers for Appellant Wanda Glenn Certificate of service date 11/17/05 [05-3918]

* * *

12/16/2005 FINAL BRIEF filed by Charles S. Lanz for Appellee MetLife. Copies: 7. Certificate of service date 10/31/05, not updated for final brief. Number of Pages: 46. [05-3918]

* * *

12/20/2005 FINAL BRIEF filed by Stanley L. Myers for Appellant Wanda Glenn. Copies: 7. Certificate of service date 12/19/05. Number of Pages: 51. [05-3918]

12/20/2005 FINAL REPLY BRIEF filed by Stanley L. Myers for Appellant Wanda Glenn. Copies: 7 Certificate of service date 12/17/05. Number of Pages: 33. [05-3918]

* * *

04/28/2006 CAUSE ARGUED on 4/28/06 by Stanley L. Myers for Appellant Wanda Glenn, Charles S. Lanz for Appellee MetLife before Judges Keith, Merritt,

	Daughtrey. [05-3918]
09/01/2006	OPINION filed: REVERSED the judgment of the district court and this case is remanded for further proceedings consistent with the opinion of this court [05-3918], decision for publication pursuant to local rule 206 [05-3918]. Damon J. Keith, Circuit Judge, Separate concurrence by Gilbert S. Merritt, Circuit Judge, Martha C. Daughtrey, Authoring Judge.
09/01/2006	JUDGMENT: REVERSED and remanded.
	* * *
10/26/2007	MANDATE ISSUED with no cost taxed. [05-3918]
	* * *
02/05/2007	Appellees' MOTION to recall mandate and stay mandate filed by Charles S. Lanz for Appellees MetLife, et al. Certificate of service date 2/2/07. [05-3918]
	* * *

02/23/2007	ORDER GRANTING appellees' motion to recall and stay the mandate filed by Charles S. Lanz. [05-3918] Damon J. Keith, Circuit Judge, Gilbert S. Merritt, Circuit Judge, Martha C. Daughtrey, Circuit Judge.

* * *

U.S. District Court
Southern District of Ohio (Columbus)
CIVIL DOCKET FOR CASE #:
2:03-CV-00572

Glenn v. Metlife, et al.
Assigned to: George C. Smith
Referred to: Mag. Judge Mark R. Abel
Demand: $0
Member case: (View Member Case)
Case in other court: Sixth Circuit, 05-3918
Cause: 29:1001 E.R.I.S.A.: Employee Retirement

Date Filed: 06/23/2003
Jury Demand: None
Nature of Suit: 890 Other Statutory Actions
Jurisdiction: Federal Question

Date Filed	#	Docket Text
06/23/2003	1	COMPLAINT (referred to Mag. Judge Mark R. Abel) (no. pgs: 3) (lvw) (Entered: 06/23/2003)
08/25/2003	2	ANSWER by defendant MetLife (no pgs: 5) (jh) (Entered: 08/26/2003)
* * *		
08/10/2004	7	Stipulated ADMINISTRATIVE RECORD manually filed w/Clerk of Court. (jk) (Entered: 08/11/2004)

	* * *	
09/24/2004	9	MOTION for Judgment as a Matter of Law by Plaintiff Wanda Glenn. Responses due by 10/18/2004 (Myers, Stanley) (Entered: 09/24/2004)
11/08/2004	10	RESPONSE in Opposition re 9 MOTION for Judgment as a Matter of Law *Memorandum in Opposition to Plaintiff's Motion and Cross-Motion for Judgment on the Administrative Record with Memorandum in Support* filed by Defendant MetLife. (Attachments: # 1 Appendix 1# 2 Appendix 2# 3 Appendix 3) (Lanz, Charles) (Entered: 11/08/2004)
11/09/2004	11	MOTION for Judgment on the Pleadings by Plaintiff Wanda Glenn. Responses due by 12/3/2004 (Myers, Stanley) (Entered: 11/09/2004)
11/12/2004	12	MOTION for Judgment as a Matter of Law by Plaintiff Wanda Glenn. Responses due by 12/6/2004 (Myers, Stanley) (Entered: 11/12/2004)
	* * *	

11/30/2004	14	REPLY to Response to Motion re 12 MOTION for Judgment as a Matter of Law filed by Defendants Long Term Disability Plan for Salaried Associates of Sears, Roebuck and Company, MetLife. (Lanz, Charles) (Entered: 11/30/2004)
12/02/2004	15	MOTION for Judgment as a Matter of Law by Plaintiff Wanda Glenn. Responses due by 12/27/2004 (Myers, Stanley) (Entered: 12/02/2004)
12/13/2004	16	MOTION to Strike 15 MOTION for Judgment as a Matter of Law *or, in the Alternative, For Leave to File Sur-Response Brief* by Defendants MetLife, Long Term Disability Plan for Salaried Associates of Sears, Roebuck and Company. (Attachments: # 1 Proposed Journal Entry #1 # 2 Proposed Journal Entry #2 # 3 Appendix 1 (Defendants' Reply to Plaintiff's Memorandum Contra Defendants' Motion [for] Judgment) Lanz, Charles) (Entered: 12/13/2004)
12/15/2004	17	ORDER denying Defendants' 16 Motion to Strike, granting alternative motion for leave to file a sur-response brief. Signed

		by Judge Mark R. Abel on 12/15/04. (dms) (Entered: 12/15/2004)
12/15/2004	18	REPLY filed by Defendants to Plaintiff's Memo Contra to Defendants' MSJ. (dms) (Entered: 12/16/2004)
12/16/2004	19	MOTION Leave to file sur-response brief re 15 MOTION for Judgment as a Matter of Law by Plaintiff Wanda Glenn. (Myers, Stanley) (Entered: 12/16/2004)
12/20/2004	20	ORDER DENYING Plaintiff's 12/2/04 motion for judgment as a matter of law. Order GRANTING motion for leave to file sur-response brief. Clerk of Court is DIRECTED to file the sur-response brief. Signed by Judge Mark R. Abel on 12/20/04. (dms) (Entered: 12/20/2004)
12/20/2004	21	REPLY filed by Defendants to Plaintiff's Memo Contra Defendants' Motion for Judgment. (dms) (Entered: 12/20/2004)
* * *		
06/08/2005	23	ORDER denying 9 Motion for Judgment as a Matter of Law

		and granting defendants' cross-motion for entry of judgment. Signed by Judge George C. Smith on 6-7-05. (ga) (Entered: 06/08/2005)
06/08/2005	24	CLERK'S JUDGMENT in favor of defendants against plaintiff. Signed on 6/8/05. (lvw) (Entered: 06/08/2005)
07/07/2005	25	NOTICE OF APPEAL as to 23 Order on Motion for Judgment as a Matter of Law & 24 Clerk's Judgment by Plaintiff Wanda Glenn. Filing fee $ 255.00, receipt number 247319. (jk) (Entered: 07/08/2005)
* * *		
02/27/2007	42	ORDER of USCA as to 25 Notice of Appeal filed by Wanda Glenn: It is ORDERED that the mandate be RECALLED AND STAYED until the Supreme Court disposes of the case. (kch) (Entered: 02/28/2007)
04/03/2007	43	ORDER STAYING CASE. Signed by Judge George C Smith on 4-3-07. (ga) (Entered: 04/03/2007)
* * *		

YOUR EMPLOYEE BENEFIT PLAN

SEARS ROEBUCK & CO.

* * *

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* * *

LONG TERM DISABILITY BENEFITS

---

* * *

Section B.4.d

d. In any case, when you do receive approval or final denial of your claim from the Social Security Administration:

   i. your Monthly Benefit will be adjusted; and

   ii. you must promptly refund to us an amount equal to all overpayments. If you do not promptly make such refund to us, we may, at our option, reduce or offset against any future benefits payable to you or through other legal actions deemed appropriate by us.

* * *

CLAIM PROCEDURE FOR LONG TERM DISABILITY BENEFITS

---

* * *

F. Medical Examinations

While a claim is pending, we, at our expense, have the right to have you examined by Doctors of our choice when and as often as we reasonably choose.

Excerpts of Diary Notes

* * *

(X096) – On 10/11/2000 12:48 – For 690008108949

Social Security Attorney is:
Kennedy & Associates
6732 W. 173rd Street, Tinley Park, Ill. 60477
Phone 1-800-637-0593 Fax #708-832-7847
Letters of introduction were sent to the claimant and CC went to Kennedy. This claim was reviewed and chosen in a social security audit of active claims for potential SSDIB candidates by Dave Kennedy of Kennedy & Associates.
Ed Peters

* * *

(U015) – On 12/14/2000 08:37 – For 690008108949

All medical, vocational, & social security info from file copied & sent to Kennedy agency

* * *

(N192) – On 07/12/2002 08:36 – For 690008108949

Call-Up For: (N145) – On 07/15/200 Call-Up Complete: (N145) – On 07/13/2002
SS award information
Date of Notice: 6/15/2002.
Retro DOE: 10/2000.
DOE Benefit Amount: $825.00.
Fully favorable ALJ award level.
COLAS: 12/00; 12/01.
Earnings Adjustment: 1/01.
SSDI Benefit Offset
10/00 through 12/00 SSDI benefit offset amount: $825.00.

1/01 through current SSDI benefit offset amount: $859.00.
(Minus 12/00 COLA/plus 1/01 earnings adjustment)
Dependent information: per Atty Ltr dependent benefits not involved.
None indicated on DP screen.
Att Fee: $4434.50 approved by SSA. EE has been paid the Atty fee-see
DCN: 020710000436.
Atty Fee Code: SS award.
SS Status Code: ALJ approved.
SS Reason Code: Att handling SSDIB dev.
Date of Disability Onset: 4/30/00.
DCN: 020701009560.

* * *

(N145) – On 07/13/2002 12:20 – For 690008108949

Transition Decision Summary
Transition Date is 9/17/02
EE disabled from her OCC. OF Manager since 4/30/00, due to Idiopathic Cardiomyopathy, SOB, Fatigue.
Per EE's Cardiologist, in an 8 hour work day, EE can sit 8 hrs., stand for 4 hrs, walk for 2-4 hrs, lift/carry up to 10 lbs. Occasionally, use hands/feet for repetitive actions, frequently bend & squat, occasionally reach above shoulder level. No emotional stress or heavy exertion.
TSA identified alternate employment as account info clerk, attendance clerk, classified ad clerk.
Therefore, final benefits approved through 9/16/02.

(N145) – On 07/13/2002 12:21 – For 690008108949

Outgoing correspondence to EE

* * *

(X059) – On 7/16/2002 08:15 – For 690008108949

Call-Up For: (X059) – On 08/13/200: Call-Up Complete: (X059) – On 07/30/2002
New overpayment details: Rec SS award for $825.00 per month effective 100100 through 123100 and $859.00 per month effective 010101 causing an overpayment of $17,937.00 less approved fee credit of $4434.50 for a new Op Bal of $13,502.50; wrote EE ltr explaining and requesting reimbursement; also advised EE we will begin withholding the new monthly benefit of $991.00 starting Aug 2002 NPerry

(UZ13) – On 07/17/2002 16:42 – For 690008108949

Call-Up For: (N145) – On 07/17/200 Call-Up Complete: (N145) – On 07/18/2002
CRC: Trans EE CM N145 @ 4:40PM. Wants to discuss her claim ending on 9/16/02. She states she doesn't understand why if SSDIS states she is disabled then why doesn't MetLife agree. ADV EE of VM

(U839) – On 07/18/2002 11:24 – For 690008108949

Call-Up For: (MRCQ) – On 07/18/20 Call-Up Complete: (N145) – On 07/18/2002

CRC: Call back request call transferred to N145 VM

(N145) – On 07/18/2002 12:03 – For 690008108949

Outgoing Call to EE
She asked me to explain decision, I went over info. in file. I also advised her to review letter explaining

how to appeal. She feels that Dr. Patel told her very different info. re. what she can & can't do. She also asked why SS reached a different decision. I told her that we base our decision on all info. we received. If she feels that any info used by SS to reach a decision should be part of her appeal, she should include it with her written appeal.

* * *

(N145) – On 08/09/2002 14:39 – For 690008108949

Call-Up For: (N131) – On 08/12/200 Call-Up Complete: (N131) – On 08/20/2002

Referral to nurse consultant/please review new information/appeal does the new information submitted by the insured provide support of her inability to work at any occupation?

* * *

(N140) – On 08/26/2002 10:52 – For 690008108949

NC call/EE interview
8/15 – States she is capable of walking around mall, unsure of distance approx 1-2 miles QAM, 20 minutes after which she showers and occasionally naps. Is capable of light housework I.E. dusting, dishes, and OCC. cooking. No vacuuming. Children are grown. Socially she gets together with family on weekends, OCC movies. Dr. Choo placed her on dietary restrictions, current WT 183 (was 200s) Does not follow BP regularly, last 130/80. Current medications per PT include: Plavix, Normodyne, Norvasc, K-Dur, Lanoxin, Diovan, Labetolol, ASA, MVI and Calcium. States she is unable to work due to inability to withstand psychological stressors. States she has good and bad days. States ICD has

'shocked' her one time in the past, unsure of date. No SOB during telephone conversation noted.

* * *

(N131) – On 08/27/2002 13:04 – For 690008108949

Call-Up For: (N145) – On 08/27/200 Call-Up Complete: (N145) – On 08/28/2002

NC Appeal Review / Recommendation
50 Y/O sales manager. Employed 3/20/90. SSD approved. The claimant has HX of sudden cardiac death syndrom. Her current DX is dilated cardiomylopathy. She has an ICD with insync pacing. The most most recent echocardiogram findings reported for LV function was April 6, 2001 where her ejection fraction was reported as anywhere from 40-50%. Dr. Patel has documented concerns regarding c/o general fatigue and SOB assoc with c/o psychosocial problems. Medical documentation submitted for appeal review includes:
-- Claimant letter dated 7/26/02
-- Letter by Dr. Rajendra C. Patel, cardiologist, dated 7/22/02.
-- Letter by Sandy Roads, RN, dated 3/4/02, describing what happened in heart failure that might necessitate an ICD. Described how the claimant's ICD device works.
-- Copies of ICD interrogations from pacemaker implant of 1989, one rept from current device of 10/10/00, and pocket revision rept of 2/28/01.
Claimant's letter states 'I do not dispute the fact that since receiving the new N-Sync pacemaker/defibrillator, my condition has slightly improved. With the new device, I still experience bad days when it is impossible for me to perform even the simplest task of getting out of bed.' She speaks of her

dependability as an employee, that her condition is permanent, and that it is stressful enough to have to accept this and that it will probably never change. But, she states, if forced to go back to work, have to call off 3-4 time/mo, leave early, or get ill at work, it is hard to imagine the stress that she would be under. Dr. Patel indicates she has dilated cardiomyopathy and HX of ventricular tachycardia requiring implantable defib device. States she has been on multiple medications for her condition, continues to have significant difficulty in returning to even any kind of sedentary job because any kind of psychologic stress at work causes significant problems w/her cardiovascular condition and she decompensates fast. States this has happened on multiple occasions in the past. States tried to RTW in the past w/exacerbation of symptoms and her condition. States he does not believe she should be forced to return to any kind of even sedentary work particularly because it is psychologic stress of work that really exacerbates her cardiovascular condition/symptomology. States she basically should be considered completely disabled from her condition and history of ventricular tachycardia. The pacemaker reports were reviewed. The 2/28/01 operative rept describes revision of device pocket due to painful insertion site. The device was removed from the left abdominal area and implanted to the pectoral area. She had developed a painful mass in the previous site. Excisional debridement of necrotic tissue and removal of extensive scar tissue was performed. The 10/10/00 rept is actually the bottom portion of the operative rept indicated above, w/hand written date 10/10/00 inserted. The reports of 4/24/02, and 7/10/02, indicate each defibrillator eval was normal. The capture and sensing thresholds

were appropriate. There were no detections or therapies delivered by the ICD. Each rept indicated the ICD battery is now showing significant wear and is likely in the last year of service before replacement will be needed. The 7/10/02 rept indicates the ICD was reprogrammed to final settings reflective of appropriate safety margins and optimized to battery efficiency.

-- NC Recommendation:

1. The records submitted support stable cardiac status with no recent detections or therapies delivered by ICD. If ICD battery change necessitated within near future, an uncomplicated recovery is of a few wks duration.

2. The records submitted for review do not support cardiovascular impairment from performing at least F.T. sedentary level work of some type. There is no supportive medical documentation evidencing exacerbation of cardiovascular condition/ symptomology due to subjective c/o work stress. NC/CMS reviewed file for supportive information regarding claim previous RTW attemps. None appeared to be in the file. Per CMS ER interview 8/9/02 there was no prior RTW since disability absence started. There is no supportive documentation submitted for psychiatric impairment from working. The medications listed in the file include lasix, potassium, lanoxin, norvasc, aspirin, calcium, normodyne, and diovan. There does not appear to be any psychotropic medications prescribed. Per the TSA performed by the VRC, the claimant would have numerous and varied jobs from which to choose, within her TE&E for full time sedentary level work. Incidental absences for what is described as 'bad days.' Could be covered by other benefits and or possibly FMLA.

3. NC recommends that the information submitted on appeal does not change the previous finding for denial. Recommend apeal committee referral for any further consideration.

* * *

(N145) – On 08/28/2002 10:03 – For 690008108949

Denial rationale
EE submitted written appeal, indicating that she is still unable to RTW. File reviewed by NC who discussed file with EE, and also obtained additional medical records. NC concluded that EE's cardiac condition is stable, and does not preclude her from working at full time sedentary employment. VRC previously verified existing employment within sedentary level of activity. Therefore, we are upholding any OCC denial.

* * *

(N169) – On 02/21/2003 08:16 – For 690008108949

Call-Up for: (N145) – On 02/21/200 Call-Up Complete: (N145) – On 02/21/2003

NC walk-up done with N145
-- NC recommendation/see previous diary.
-- MD states in APS that EE was fit for sedentary work, in March of 02 In letter dated 2/03 MD states that based on her clinical condition and symptomology there is not time where I feel EE can return to F/T employment. However no additional medical has been received to review for change in EE status.

* * *

(N145) – On 03/18/2003 13:13 – For 690008108949

Incoming call from Cathy Stein @ Kennedy & Associates. They have requested the file from storage. They will fax to us ASAP. I asked for rush handling, as we are reviewing an appeal by EE.

* * *

(U184) – On 05/20/2003 12:40 – For 690008108949

Appeal determination by appeal unit: termination upheld.
Letter mailed to Atty.
DLW: 4/29/00 as a sales department manager. TSA based on 6/12/02 AP restriction identified sedentary jobs. CLM terminated at trans (9/16/02).
February 12, 2003, letter from Dr. Patel. Dr. Patel noted that his previous reports indicated that Ms. Glenn was fit for sedentary work, however based on her clinical condition and symptomatology, Dr. Patel never felt that Ms. Glenn could return to full-time employment. Dr. Patel's position was that Ms. Glenn should be considered completely disabled from her cardiomyopathy and associated symptoms from her LV dysfunction.
IPC: Ms. Glenn's ejection fraction had improved with medical therapy and probably with biventricular pacing. The consultant indicated that clinically Ms. Glenn had improved and has been relatively free of any significant cardiac decompensation as documented by Dr. Patel's follow-up notes. The adenosine cardiolite stress study and 2-D echocardiogram, failed to reveal any evidence of reversible ischemia and the left ventricular ejection fraction went up to 40-45%. The consultant noted that based on the medical information Ms. Glenn has

achieved a relatively stable cardiac status. CLM on ACS. CLM upheld. Letter mailed to Atty. SAL

* * *

May 20, 2003

MetLife
PO Box 14592
Lexington, KY 40511

Stanley Myers
Attorneys at Law
221 S. High Street
Columbus, OH 43215

RE: Long Term Disability
Claim No: 690008108949
Group No: 31003
SS#: [OMITTED]
Claimant: Wanda Glenn

Dear Mr. Myers

We have completed our review of the termination of Ms. Glenn's claim for disability benefits. For the following reasons, the original determination is upheld upon appeal review.

The employer's plan states the following:

As used in the Plan, the term "Total Disability" has two definitions:

1. During the Waiting Period and for the next 24 consecutive months, "Total Disability" means that because of Illness or Injury, you cannot perform the material duties of your own job.

2. After that time period, you will no longer be considered Totally Disabled unless you are totally incapable of performing the material duties of any gainful occupation for which you are reasonably qualified based on your training, education, and experience.

We have reviewed Ms. Glenn's entire claim.

Our records indicate that Ms. Glenn's last worked on April 29, 2000 as a Sales Department Manager. Ms. Glenn received Long Term Disability benefits through September 16, 2002. In order to receive benefits beyond September 16, 2002, Ms. Glenn must be incapable of performing the material duties of any gainful occupation as defined in the plan.

Current Medical information is required at various points during a disability to substantiate the continued existence of a disabling condition as defined in the Group Plan.

We review an individual's vocational information, medical information and an individual's specific restrictions and limitations that are supported by objective medical evidence in making a claim determination.

On June 12, 2002, Dr. Rajendra Patel, Cardiologist completed a Physical Capacities Evaluation form. The form indicated that Ms. Glenn could sit for 8 hours, stand for 4 hours, and walk from 2-4 hours in an 8-hour workday. Dr. Patel noted she could occasionally lift and carry up to 10lbs. It was noted she could use her hands for repetitive action and her right foot in operating foot controls. Ms. Glenn could not crawl or climb. She could occasionally reach above shoulder level and frequently bend and squat. The form indicated she should avoid unprotected heights and being around moving machinery. Ms. Glenn had moderate restrictions for exposure to temperature changes, driving automotive equipment, and exposure to dust, fumes, and gases. Dr. Patel indicated additional restrictions of no emotional stress or heavy exertion.

On July 10, 2002 a Certified Rehabilitation Counselor performed a Transferable Skills Analysis (TSA). The TSA was based on Dr. Patel's June 12, 2002 restrictions. The TSA identified alternative sedentary occupations that Ms. Glenn demonstrated the transferable skills to perform within her residual physical capacities, which were found in her geographical area.

We received a February 12, 2003, letter from Dr. Patel. Dr. Patel noted that his previous reports indicated that Ms. Glenn was fit for sedentary work, however based on her clinical condition and symptomatology, Dr. Patel never felt that Ms. Glenn could return to full-time employment. Dr. Patel's position was that Ms. Glenn should be considered completely disabled from her cardiomyopathy and associated symptoms from her LV dysfunction.

On May 2, 2003 an Independent Physician Consultant Board certified in Cardiology reviewed Ms. Glenn's claim. The consultant noted that Ms. Glenn had a biventricular pacemaker implanted. Ms. Glenn's ejection fraction had improved with medical therapy and probably with biventricular pacing. The consultant indicated that clinically Ms. Glenn had improved and has been relatively free of any significant cardiac decompensation as documented by Dr. Patel's follow-up notes. The adenosine Cardiolite stress study and 2-D echocardiogram, failed to reveal any evidence of reversible ischemia and the left ventricular ejection fraction went up to 40-45%. The consultant noted that based on the medical information Ms. Glenn has achieved a relatively stable cardiac status.

We have determined that the documentation currently in the file does not support a disability that

would prevent Ms. Glenn from performing any occupation, as defined in the plan. Therefore, the original claim determination was appropriate.

Upon request, MetLife will provide you with a copy of the documents, records, or other information we have that are relevant to your claim and identify any medical or vocational expert(s) whose advice was obtained in connection with your claim. You also have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

You have exhausted the administrative remedies under the plan, no further appeals will be considered.

Yours truly

/s/

Sal Marchese
Procedure Analyst
MetLife Disability
1 800 300-4296

Metropolitan Life Insurance Company

MetLife

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

November 22, 2002

Wanda Glenn
2566 Sonata Drive
Columbus, OH 43209

Re: Long Term Disability
Claim No: 690008108949
Group No: 31003

Dear Ms. Glenn:

We are contacting you in regard to the outstanding overpayment balance of $210.47 due and owing to MetLife and the Sears Roebuck & Company Group Disability Plan. As explained to you in previous correspondence, the amount due is the result of the reduction of your Long Term Disability benefits by the amount you received from your Social Security Award. This reduction is mandated by the terms of the Group Long Term Disability Plan. The above amount remains due and owing and must be repaid immediately to MetLife as Claims Administrator of the Sears Roebuck & Company Group Disability Plan.

This letter is final demand for either lump sum reimbursement or a monthly installment agreement. Please keep in mind that we are not computing interest due at this time. If a lump sum repayment is not possible at this time, we are willing to consider an installment arrangement.

You should understand that you have been overpaid employee welfare plan benefits, monies to which you are not legally entitled. These overpaid benefits necessarily reduce the assets of the plan and the cost of such is passed on to all plan participants. If Metlife were to allow you to retain the overpaid plan benefits, we would not be treating all plan beneficiaries fairly. It is necessary that you contact the undersigned immediately to arrange to repay the monies.

Should you fail to reply to this letter by December 26, 2002, we will be referring this overpayment to a collection agency to commence collection efforts against you for the recovery of the adjusted plan benefits due the Plan and MetLife. We urge you to contact us at the number listed below. This matter is on an urgent status and requires your prompt attention.

Sincerely,

Nancy Perry
Offset Recovery Unit
Met Disability
800-300-4296 ext. 1761

Metropolitan Life Insurance Company
PO Box 14590, Lexington, KY 40511-4590

Met Disability **MetLife**

August 28, 2002

Wanda Glenn
2566 Sonata Drive,
Columbus, OH 43209

RE: Long Term Disability
Group #: 31003
Claim #: 690008108949

Dear Ms. Glenn:

We have reviewed your July 26, 2002 request to reopen your Long-Term Disability claim. We have completed our evaluation of your claim, which was conducted to determine your eligibility for continued Long-Term Disability benefits. Your claim has already been approved for Long-Term Disability benefits through September 16, 2002.

As part of the review process, we obtained additional information from you, and from the Ohio State University Medical Center.

Your plan states:

To receive benefits from the Plan, you must be Totally Disabled. As used in the Plan, the term "Total Disability" has two definitions:

1. During the Waiting Period and for the next 24 consecutive months, "Total Disability" means that because of Illness or Injury, you cannot perform the material duties of your own job.

2. After that time period, you will no longer be considered Totally Disabled unless you are totally incapable of performing the material duties of any gainful occupation for which you are reasonably qualified based on your training, education, and experience.

All of the medical documentation that we have received from your cardiologist, Dr. Rajendra Patel, was extensively reviewed.

The Attending Physician's Statements and office notes from Dr. Patel indicated that you were disabled beginning April 30, 2000, due to idiopathic cardiomyopathy, shortness of breath, and fatigue.

As of November 2, 2001, you had an ICD device in place. You had better exercise tolerance than before. From overall evaluation, you seemed to be clinically stable.

On January 9, 2002, Dr. Patel stated that you could do the following activities: occasionally lift and carry up to twenty pounds, perform bilateral repetitive foot and hand movements, and occasionally bend, squat, and reach above shoulder level.

As of February 5, 2002, you showed an ejection fraction of 35 to 40%.

On March 13, 2002, Dr. Patel stated that in an eight-hour work day, you were capable of sitting eight hours, standing four hours, and walking two hours. There were no current physical-barriers preventing you from returning to fulltime work.

Dr. Patel advised us on June 12, 2002, that in an eight-hour work day, you could sit for eight hours, stand for four hours, and walk for 2 to 4 hours. You could occasionally lift/carry up to ten pounds, and use

your hands and feet for repetitive actions. You could frequently bend and squat, and occasionally reach above shoulder level. Your functional limits included no emotional stress and heavy exertion.

Your June 18, 2002 examination showed an ejection fraction of 35 to 40%.

We have also reviewed medical reports from April 24, 2002 and July 10, 2002, which indicated that each defibrillator evaluation was normal. The capture and sensing thresholds were appropriate. There were no detections or therapies delivered by the ICD. Each report stated that the ICD battery is now showing significant wear and is likely in the last year of service before replacement will be needed. The July 10, 2002 report indicated that the ICD was reprogrammed to final settings reflective of appropriate safety margins, and optimized to battery efficiency.

The records submitted support stable cardiac status with no recent detections or therapies delivered by the ICD. If the ICD battery change becomes necessary within the near future, there should be an uncomplicated recovery of a few weeks duration.

There is no supportive medical documentation of the exacerbation of your cardiac condition and symptomology, due to subjective complaints of work related stress. The records submitted for review do not support cardiovascular impairment that would prevent you from performing full time sedentary level work.

Therefore, the information submitted on appeal does not change the previous finding that you are capable of performing full time sedentary work.

We previously advised you that on July 10, 2002, your file was referred to our Vocational Rehabilitation Coordinator, who performed a Transferable Skills Analysis that identified positions in your geographic area, which we felt you would be capable of performing. A Transferable Skills Analysis is a system that determines a persons potential for alternative work given their physical abilities, education, and work history. A Transferable Skills Analysis was conducted on your behalf and based on your Training, Education and Experience and your Restrictions and Limitations, you are qualified to perform the following occupations at a sedentary exertion level:

- Account Information Clerk DOT# 210.367-010
- Attendance Clerk DOT# 219.362-014
- Classified Ad Clerk DOT# 247.367-010

The full description of these positions can be found in the Dictionary of Occupational Titles, in any public library.

Based on the above information, we are unable to grant further Long-Term Disability benefits based upon medical evidence that does not support your inability to return to any occupation, as defined in the Sears Long-Term Disability plan.

MetLife reserves all of its rights or defenses either expressly stated or implied.

You may appeal this decision by sending a written request for appeal to MetLife Disability, PO Box 14592, Lexington KY, 40511-4592 within 180 days after you receive this denial letter. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional

comments, documents, records or other information relating to your claim that you deem appropriate for us to give your appeal proper consideration. Upon request, MetLife will provide you with a copy of the documents, records, or other information we have that are relevant to your claim and identify any medical or vocational expert(s) whose advice was obtained in connection with your claim.

MetLife will evaluate all the information and advise you of our determination of your appeal within 45 days after we receive your written request for appeal. If there are special circumstances requiring additional time to complete our review, we may take up to an additional 45 days, but only after notifying you of the special circumstances in writing. In the event your appeal is denied in whole or in part, you will have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

Should you have any questions or concerns, please contact us.

Sincerely,

Earl Chesler
Case Management Specialist
MetLife Disability
(888) 868-3997
Fax: (866) 690-1264

Metropolitan Life Insurance Company **MetLife**
PO Box 14590, Lexington, KY 40511-4590

Met Disability

August 8, 2002

Wanda Glenn
2566 Sonata Drive,
Columbus, OH 43209

RE: Long Term Disability
Claim No: 690008108949
Group No: 31003
S.S. No: [OMITTED]

Dear Ms. Glenn:

Thank you for your reimbursement check dated July 20, 2002 in the amount of $12,600.50. It has been applied toward your overpayment, leaving a current balance of $902.00.

Per our telephone conversation today, we will withhold $451.00 from your August and September 2002 benefits to satisfy the overpayment balance.

Sincerely,

Nancy Perry
Overpayment Unit
Met Disability
800-300-4296 ext. 1761

July 26, 2002

Mr. Earl Chesler
Case manager specialist
Med life Disability
P.O Box 14592
Lexington, KY
40511-4592

RE: Appeal

Dear Mr. Earl Chesler,

I have just received your letter dated 7-15-02 denying me further long-term disability.

Disappointment is not a strong enough word to describe what I feel. I do not dispute the fact that since receiving the new N-Sync Pacemaker/Defibrillator, my condition has slightly improved. With the new device, I still experience bad days when it is impossible for me to perform even the simplest task of getting out of bed.

I was a manager at Sears therefore I know that an employee must be dependable in order to maintain employment. I know I cannot be a dependable employee when I continue to have these bad days. If you look into my work history any supervisor will confirm without a doubt I was very dependable, dedicated employee and gave 100% of myself to any job.

The damage to my heart, I am told is permanent. It is stressful to have to accept this as a part of my life that will probably never change. However, if I am forced to go back to work and have to call off 3 to 4

times a month, go to work and leave early or become ill on the job. It is hard to imagine the stress that I would be under.

I am not a lazy person and I am not asking for a hand out. I ask that you review what I have written along with the letter from Dr. Patel. This state I should not be forced to return to any type of employment. Overturn your denial and grant me further long-term disability.

Enclosed you will find documents from Dr. Patel, Kennedy and Associate, Social security and OSU pace maker clinic for proper consideration.

Sincerely,

/s/

Wanda Glenn

CARDIOVASCULAR ASSOCIATES, P.C.

Berton L. London, M.D., F.A.C.P., F.A.C.C.
Oswald Bostic, M.D., F.R.C.P. (C)
Juan C. Rojas, M.D.
Luis Osterberger, M.D.
Vijay Kudesia, M.D., F.A.C.C.
Antonio P. Carrillo, M.D., F.A.C.C.
Chandrakant Pujara, M.D., F.A.C.C.
Samer Salka, M.D., F.A.C.C.
Eduardo Garcia, M.D., F.A.C.C., F.A.C.F.
Syed A. Mahmood, M.D., F.A.C.C.

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27472 Schoenherr, Suite 140
Warren, Michigan 48088
Telephone: (586) 778-2950
Fax: (586) 778-3240

4020 Venoy Road, Suite 200
Wayne, Michigan 48184
Telephone: (734) 729-6710
Fax: (784) 729-6715

May 2, 2003

UNIVAL Center
2890 Carpenter Road, Suite 1400
P.O. Box 130770
Ann Arbor, Michigan 48113-0770

Re: Glen, Wanda
CLAIM #: 690008108949
SSN: [OMITTED]
EMPLOYER: Sears Roebuck & Co.
MY LICENSE #: 036190

To UNIVAL administration:

I had the opportunity to review the medical records of Ms. Wanda Glen at your request. Ms. Glen is a 50-year-old African-American female who is from Columbus, Ohio, and was employed at Sears Roebuck Corporation since March 1990. The patient has been on medical disability as recommended by her attending Cardiologist, Dr. Raj Patel since April 30, 2000. She was originally seen by Dr. Patel in 1989 when she presented with ventricular fibrillation. She was seen in the emergency room. At that time she

had extensive cardiac workup and she was diagnosed to have idiopathy dilated cardiomyopathy. She had left ventricular ejection fraction in the range of 25-30%. Her coronary arteries were normal. Automatic intracardiac defibrillator was prophylactically implanted subsequently. The patient is being followed regularly by Dr. Patel and her primary care physician, Dr. Chin, in Ohio. The patient has been having easy fatigue and occasional palpitations along with exertional dyspnea. The patient had has electrophysiological evaluation and original AICD was replaced. The patient had biventricular pacemaker implanted at that time. The patient has been on medical regimen, which includes Zestril, Lasix, potassium supplement, Normodyne, Lanoxin, as well as calcium supplement. The patient's ejection fraction indeed has improved with medical therapy and probably with biventricular pacing as well. Clinically, the patient has improved and has been relatively free of any significant cardiac decompensation as documented by Dr. Patel's follow-up notes. The patient had also undergone adenosine Cardiolite stress study and 2-D echocardiogram, which failed to reveal any evidence of reversible ischemia and the left ventricular ejection fraction has come up to 40-45%. The patient claims that she is unable to bear any kind of psychological or physical stress. The patient's vocational training and work experience has been, according to the dictionary of occupational titles, to be described as manager of the department store and she has also functioned as a safe manager, sales representative and audit clerk. The patient's physical restrictions and limitations as described by Dr. Patel on June 12, 2002, indicated that she was capable of sitting for eight hours, standing for four hours, walking for two to four

hours, ability to lift and carry up to ten pounds occasionally, inability to perform bilateral upper extremity movements, ability to bend and squat frequently, inability to crawl, climb, being unprotected heights and moving machinery. Dr. Patel had also noted additional restrictions and limitations as no emotional stress or heavy exertion.

In view of the patient's diagnosis of dilated cardiomyopathy with complex ventricular arrhythmias requiring medical management, which includes diuretics, beta-blockler, AC6 inhibitor, and potassium supplement along with device management including AICD and biventricular pacing, the patient certainly is not able to do any exertional physical activity. However, based on the information provided, Ms. Glen was deemed capable of sedentary activity as per the U.S. Department of Labor guidelines. I understand that alternative occupational classes were offered, which included account information clerk, attendance clerk, or classified ad clerk. The actual impact of any form of real or perceived emotional stress on cardiac arrhythmias, or cardiomyopathy is difficult to gauge in an individual patient. However, based on Dr. Patel's own physical capacity evaluation on June 12, 2002, the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis. If the job environment entails significant degree of emotional stress, and the patient is not able to cope with that, then certainly permanent disability can be considered. Based on the information, which is available in the medical records provided to me, it appears to me that with the appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status. Her left ventricular ejection fraction has also significantly

improved and in spite of the history of ventricular arrhythmias in the past, the patient's defibrillator had fired only once and that too probably wrongfully on the basis of sinus tachycardia. In any event, the patient's work capacity should improve with the biventricular pacing as well as evidenced by the recent clinical trials using the cardiac recent conization therapy in her type of patients.

If any further information is desired, please do not hesitate to contact me.

With best regards,

/s/
Chandrakant Pujara, M.D., F.A.C.C.

CP:EMT:21

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
Grove City Office * 2041 Strongtown Road * Grove City, Ohio 43123 * Phone 614/545-0101 * Fax 614/545-0107
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Richard M. Bardales, MD
Barney B. Beaver, DO
Sandeep Chopra, MD
Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD
Reuben A. Sheares, MD
Shantanu Sinha, MD

February 12, 2003

Mr. Stanley Myers, Attorney at Law
221 S. High Street
Columbus, OH 48215-4503

RE: Wanda Glenn (DOB: 12/11/52)

Dear Mr. Meyers

Thank you for your correspondence dated January 29, 2003, regarding Wanda Glenn's disability issue. In summary, Wanda is a known patient to me. Initially she was seen by me in 1989 when she presented to the hospital with cardiac arrest and ventricular fibrillation. At that time she was worked up extensively and was diagnosed as having idiopathic dilated cardiomyopathy. She underwent prophylactic implantation of a defibrillator. Since then she has been followed up by me with symptoms related to left ventricular diastolic dysfunction and cardiomyopathy. Her ejection fraction has varied from 30% to as high as 40-45%. The patient had recurrent episodes of chest pains, and in March 2000, she underwent another coronary angiography at Grant Medical Center. At

that time she did not have any coronary obstructive disease, however her left ventricular systolic function was severely impaired. At that time the ejection fraction came out as low as 20-25%. The patient also has been in the emergency room at University Hospitals on one occasion because of firing of her defibrillator device from sinus tachycardia.

The patient has been on multiple medications for her dilated cardiomyopathy. The patient has continued to have difficulty in terms of her exercise intolerance, general fatigue and tiredness. Apparently, after the initial event the patient was on temporary disability, and at that time was advised to seek social security. She was given social security benefits at that time and has not worked since then.

Previous reports filled out by me state that the patient was fit for sedentary work, however based on her clinical condition and her symptomatology, there was never a time where I felt that this patient would be able to return to full-time employment. I strongly believe that employment would put significant stress on her overall system, and she may decompensate. Ms. Glenn does not have any emotional condition that causes her cardiac problems. She has a cardiac problem that is exacerbated by any kind of stress.

My position is that she should be considered completely disabled, mainly from her cardiomyopathy and associated symptoms from her LV dysfunction. It is to be noted that the ICD device that she has is meant to provide defibrillation in case of ventricular fibrillation or sudden cardiac death. This device has no role in terms of improving her cardiac function.

Please do not hesitate to call me if I can provide any further information or discussion to clarify the issues raised by her insurance carrier.

Sincerely,

/s/
Rajendra C. Patel, MD, FACC
Dictated, but not read.
RCP/sat

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
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Rajendra C. Patel, MD
Reuben A. Sheares, MD

July 22, 2002

RE: Wanda Glenn (DOB: 12-11-52)

To Whom It May Concern:

Ms. Wanda Glenn has been a patient known to me. This is a patient that has dilated cardiomyopathy as well as history of ventricular tachycardia requiring an implantable defibrillator device. The patient has been on multiple medications for her dilated cardiomyopathy. The patient continues to have significant difficulty with exertional shortness of breath on any kind of moderate exertion. She also continues to have significant difficulty in returning to even any kind of sedentary job because any kind of psychologic stress at work causes significant problems with her cardiovascular condition and she decompensates fast. This has happened on multiple occasions in the past. The patient has tried to return to work in the past with exacerbation of her symptoms as well as exacerbation of her condition.

At the present time, I do not believe Wanda should be forced to return to any kind of even sedentary work particularly because it is the psychologic stress

of work that really exacerbates her cardiovascular condition and symptomatology. The patient basically should be considered completely disabled from her dilated cardiomyopathy as well as history of ventricular tachycardia.

Please do not hesitate to call me if I could provide any further details or further discussion in this matter. With best regards.

Sincerely,

/s/
Rajendra C. Patel, MD, FACC
Dictated, but not reviewed.
RCP/clo

CAPITOL CITY CARDIOLOGY

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Rajendra C. Patel, MD
Reuben A. Sheares, MD

June 18, 2002

RE: Wanda Glenn (DOB: 12-11-52)

Choo Y Rhee, MD
1492 E Broad St #1604
Columbus OH 43205

Dear Choo:

Ms. Glenn was back in our office earlier than expected. The patient complains of general tiredness and she says she has gained weight. She describes exercise intolerance and shortness of breath on moderate exertion.

Physical examination today, however, revealed no evidence of JVD or carotid bruits. Lungs are bilaterally clear. Cardiac auscultation revealed a regular rhythm with an S4 gallop. Abdomen was benign. Extremities revealed no ankle edema and good pedal pulses.

Electrocardiogram shows sinus rhythm with P tracking pacemaker functioning normally. If you recall, the 2D echocardiogram in December of this year showed an ejection fraction of 35 to 40%.

I believe most of her exercise intolerance is from dilated cardiomyopathy.

At the present time, in the absence of any overt congestive heart failure, I have decided to hold off on any further imaging or another echocardiogram. I have advised her to continue her current medications. There is also significant anxiety on her part regarding the disability and having to return to work. From my standpoint, again, considering her cardiomyopathy, I do not believe she will handle any kind of stress well at her work and she would be better off being on disability. I will keep you posted regarding her progress.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Rajendra C. Patel, MD, FACC
Dictated, but not read.
RCP/bjj

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
River View Medical Office * 2405 North Columbus Street, Suite 130 * Lancaster, Ohio 43130 * 740-653-7511 * Fax 740/653-7512
Grove City Office * 2041 Strongtown Road * Grove City, Ohio 43123 * Phone 614/545-0101 * Fax 614/545-0107

Bruce L. Auerbach, MD
Richard M. Bardales, MD
Barney B. Beaver, DO
Reuben A. Sheares, III, MD
Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

April 30, 2002

Choo Y Rhee, MD
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn (DOB: 12-11-52)

Dear Choo:

Ms. Glenn was back in our office today for cardiac followup. Since her last visit she has had no further ICD shocks. As you recall, she still gets extremely short of breath, particularly under any kind of emotional stress as well as any kind of significant or heavy exertion. Fortunately she remains free of any PND, orthopnea, or leg edema.

Current medications include: Lasix, KCI, Lanoxin, Norvasc, aspirin, calcium, Normodyne, Diovan and Plavix. She had an ICD interrogation and the ICD battery is coming to it end of life. She has been scheduled for ICD revision and at that time they are also planning to move the power pack device away from the breast tissue.

From a cardiac standpoint, her physical examination revealed no evidence of JVD or carotid bruits. Lungs

are bilaterally clear. Cardiac auscultation revealed regular rhythm with an S4 gallop. Abdomen and extremities were unremarkable. Blood pressure was 140/80.

At the present time I have advised Wanda to continue current medications, continue her ICD follow-up with Dr. Chuck Lowe at Ohio State and from a cardiac standpoint I plan to see her back in four months.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Rajendra C. Patel, MD, FACC
Dictated, but not read.
RCP/bjj

CAPITOL CITY CARDIOLOGY
Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
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Richard M. Bardales, MD
Barney B. Beaver, DO
Reuben A. Sheares, III, MD
Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

February 5, 2002

Choo Y. Rhee, MD
1492 E Broad St #1604
Columbus, OH 43205

RE: Wanda Glenn (DOB: 12-11-52)

Dear Choo:

Ms. Glenn was back in our office today for cardiac follow-up. In November or December, she was seen at Mount Carmel East with symptoms of TIA and was started on Plavix over and above her aspirin. Also, last month she was seen at Ohio State University Hospital main campus because of ICD shock. At that time, the ICD interrogation apparently showed some form of sinus tachycardia. She was seen by a cardiology fellow over there and somehow the information was passed on to the emergency room physician who was advised to start the patient on beta blockers. Interestingly enough, I am not sure whether anybody looked into the chart in detail. Ms. Glenn is already on Normodyne 200 mg po BID. Fortunately, she has had no further shocks. She continues to have exertional shortness of breath on any kind of emotional excitement or any

kind of significant physical exertion A 2-D echocardiogram in December shows the LV dysfunction being progressive. Ejection fraction again has gone back down to 35-40%. I have advised Ms. Glenn at the present time to go to see Dr. Chuck Love at Ohio State regarding her ICD adjustment. Meanwhile, from a cardiac standpoint I have advised her to continue her current medications, including Lasix, potassium, Lanoxin, Norvasc, aspirin, calcium, Normodyne, and Diovan, as well as Plavix. She did have some questions about all her medications, particularly since she is going to face the jury and the court regarding the long-term disability, and I gave her an extensive idea about her medications as well as her current heart condition. From a cardiac standpoint, I plan to see her back in three months.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/

Rajendra C. Patel, MD, FACC
Dictated, but not read.
RCP/sem

Metropolitan Life Insurance Company **MetLife**
PO Box 14590, Lexington, KY 40511-4590

MetLife Disability

June 5, 2002

Dr. Raj Patel
423 E. Town St.
Columbus, OH 43215

RE: Wanda Glenn
DOB: 12/11/52
Claim #: 690008108949

Dear Dr. Patel:

Thank you for the information you have provided for your patient **Wanda Glenn**. At this time we are in need of additional medical information so that we may proceed with our evaluation of the claim. We would appreciate your assistance in providing us with the following:

Please complete and return the enclosed Physical Capacities Evaluation. Also, please send us photocopies of the medical records from November 3, 2001 through current, including test res lts, medication flowcharts, and physical therapy notes. This information needs to be faxed to my attention, with the claim number on the fax cover sheet.

Please fax above to my attention at: 866/690-1264.

Enclosed you will find a signed authorization from our claimant. We look forward to your prompt response. If there will be a fee for your service, please enclose with your tax ID#.

If you have any questions, please contact our Customer Response Center at 888/868-3997.

Sincerely,
/s/
Earl Chesler
Case Management Specialist

MetLife

Physical Capacities Evaluation

Name of Claimant: Wanda Glenn Birth Date: 12/11/52

Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any items that you do not believe you can answer should be marked n/a (not answerable).

Note: In terms of an 8 hour workday "occasionally" equals 0% to 33%; "frequently," 34% to 66%; "continuously," 67% to 100%

I. In an 8-hour workday, claimant, can: (Circle full capacity for each activity)

A.) Sit - No - 1 2 3 4 5 6 7 **8** (hrs.)

B.) Stand - No - 1 2 3 **4** 5 6 7 8 (hrs.)

C.) Walk - No - 1 **2 3 4** 5 6 7 8 (hrs.)

II. Claimant can lift	Never	Occasionally	Frequently	Continuously
A.) Up to 10 lbs.	( )	(√)	( )	( )
B.) 11-20 lbs.	(√)	( )	( )	( )
C.) 21-50 lbs.	(√)	( )	( )	( )
D.) 51-100 lbs.	(√)	( )	( )	( )
E.) 100 + lbs	(√)	( )	( )	( )

III. Claimant can carry	Never	Occasionally	Frequently	Continuously
A.) Up to 10 lbs.	( )	(√)	( )	( )
B.) 11-20 lbs.	(√)	( )	( )	( )
C.) 21-50 lbs.	(√)	( )	( )	( )
D.) 51-100 lbs.	(√)	( )	( )	( )
E.) 100 + lbs	(√)	( )	( )	( )

IV. Claimant can use hands for repetitive action such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulating
A.) Right	(√) Yes ( ) No	(√) Yes ( ) No	(√) Yes ( ) No
B.) Left	(√) Yes ( ) No	(√) Yes ( ) No	(√) Yes ( ) No

V. Claimant can use feet for repetitive movements as in operating foot controls:

Right	Left	Both
(√) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

VI. Claimant is able to:	Not at all	Occasionally	Frequently	Continuously
A.) Bend	( )	( )	(√)	( )
B.) Squat	( )	( )	(√)	( )
C.) Crawl	(√)	( )	( )	( )
D.) Climb	(√)	( )	( )	( )
E.) Reach above shoulder level	( )	(√)	( )	( )

VII. Restriction of activities involved	None	Mild	Moderate	Total
A.) Unprotected heights	( )	( )	( )	(√)
B.) Being around moving machinery	( )	( )	( )	(√)
C.) Exposure to marked changes in temperature or humidity	( )	( )	(√)	( )
D.) Driving automative equipment	( )	( )	(√)	( )
E.) Exposure to dust, fumes & gases	( )	( )	(√)	( )

Remarks (on above, on other functional limitations):
No emotional stress / no heavy exertion

Date 6/12/02 Signature of Physician /s/

Please mail directly to: Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511

Metropolitan Life Insurance Company

MetLife

MetLife Disability, PO Box 14590,
Lexington, KY 40511-4590
Phone: 1-888-888-3997
Fax: 1-647-391-1727

March 12, 2002

Dr. Rajendra [illegible]. Patel
Capitol City
Cardiology
423 E. Town Street
Columbus, OH 43215

Re: Wanda Glenn
Claim # 69008910849
SS# [OMITTED]

Dear Dr. Patel,

MetLife Disability Insurance is currently administering Long-Term Disability benefits for your patient, Ms. Wanda Glenn. We are evaluating her ability to resume a functional lifestyle and her ability to return to fulltime work within her capabilities. To complete our assessment we need your input and kindly ask that you complete the following in consideration of full-time work.

On the Physical Capacities Evaluation form dated January 9, 2002, you have indicated Ms. Glenn's ability as the following:

- lift and carry up to twenty pounds occasionally
- ability to perform bilateral repetitive foot and hand movements

- restriction from unprotected heights, being around machinery, dust, fumes and temperature changes.

- Please indicate Ms. Glenn's full capacity to perform sitting, standing or walking in an eight-hour day.

  Sitting 8 # of hours
  Standing 4 # of hours
  Walking 2 # of hours

- Do you believe Ms. Glenn is able to work in a sedentary physical exertion level occupation?

  X Yes ___ No

- With or without accommodations? Please describe

- If No, please explain current physical barriers preventing Ms. Glenn from returning to fulltime.

N/A

/s/ 3/13/02

Physician Signature Date

If you have any questions call me at 1-888-868-3997, extension 3337. My office hours are Monday through Friday 8:00 A.M. to 4:30 P.M., CST.

Sincerely,

Lisa Hissem, MS, CRC
Vocational Rehabilitation Consultant

MetLife

Physical Capacities Evaluation

Name of Claimant: Wanda Glenn Birth Date: 12/11/52

Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any items that you do not believe you can answer should be marked n/a (not answerable).

Note: In terms of an 8 hour workday "occasionally" equals 0% to 33%; "frequently," 34% to 66%; "continuously," 67% to 100%

I. In an 8-hour workday, claimant, can: (circle full capacity for each activity)

A.) Sit - No - 1 2 3 4 5 6 7 8 (hrs)

B.) Stand - No - 1 2 3 4 5 6 7 8 (hrs)

C.) Walk - No - 1 2 3 4 5 6 7 8 (hrs)

II. Claimant can lift	Never	Occasionally	Frequently	Continuously
A.) Up to 10 lbs.	( )	(√)	( )	( )
B.) 11-20 lbs.	( )	(√)	( )	( )
C.) 21-50 lbs.	(√)	( )	( )	( )
D.) 51-100 lbs.	(√)	( )	( )	( )
E.) 100 + lbs	(√)	( )	( )	( )

III. Claimant can carry	Never	Occasionally	Frequently	Continuously
A.) Up to 10 lbs.	( )	(√)	( )	( )
B.) 11-20 lbs.	( )	(√)	( )	( )
C.) 21-50 lbs.	(√)	( )	( )	( )
D.) 51-100 lbs.	(√)	( )	( )	( )
E.) 100 + lbs	(√)	( )	( )	( )

IV. Claimant can use hands for repetitive action such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulating
A.) Right	(√) Yes ( ) No	(√) Yes ( ) No	(√) Yes ( ) No
B.) Left	(√) Yes ( ) No	(√) Yes ( ) No	(√) Yes ( ) No

V. Claimant can use feet for repetitive movements as in operating foot controls:

Right	Left	Both
(√) Yes ( ) No	(√) Yes ( ) No	(√) Yes ( ) No

VI.

Claimant is able to:	Not at all	Occasionally	Frequently	Continuously
A.) Bend	( )	(√)	( )	( )
B.) Squat	( )	(√)	( )	( )
C.) Crawl	(√)	( )	( )	( )
D.) Climb	(√)	( )	( )	( )
E.) Reach above shoulder level	( )	(√)	( )	( )

VII.

Restriction of activities involved	None	Mild	Moderate	Total
A.) Unprotected heights	( )	( )	( )	(√)
B.) Being around moving machinery	( )	( )	( )	(√)
C.) Exposure to marked changes in temperature or humidity	( )	( )	( )	(√)
D.) Driving automative equipment	( )	( )	( )	(√)

E.) Exposure to dust, fumes & gases	(___)	(___)	(_____)	(√)

Remarks (on above, on other functional limitations):
More LF dysfunction noted on recent Echo.

Date 1/9/02 Signature of Physician /s/

Please mail directly to: Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
River View Medical Office * 2405 North Columbus Street, Suite 130 * Lancaster, Ohio 43130 * 740-653-7511 * Fax 740/653-7512
Grove City Office * 2041 Strongtown Road * Grove City, Ohio 43123 * Phone 614/545-0101 * Fax 614/545-0107

Bruce L. Auerbach, MD
Richard M. Bardales, MD
Barney B. Beaver, DO
Reuben A. Sheares, III, MD
Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

November 2, 2001

Choo Y Rhee, MD
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn (DOB: 12/11/52)

Dear Choo:

Ms. Glenn was back in our office today for cardiac followup. As you know, she is a 48-year-old female with severe dilated cardiomyopathy as well as a previous history of cardiopulmonary arrest and sudden cardiac death from which she was successfully resuscitated. She now has an ICD in place along with biventricular or InSync pacing.

If you recall, last March a 2D echocardiogram showed some improvement in her LV function. She continues to have better exercise tolerance than before. She, however, still gets fatigued out and short of breath, particularly if she is under any kind of significant psychologic stress. She denied any PND, orthopnea or leg edema.

Physical examination today revealed no evidence of jugular venous distention or carotid bruits. Lungs

were bilaterally clear. Cardiac auscultation revealed a regular rhythm with an S4 gallop. Abdomen was benign. Extremities revealed no ankle edema and good pedal pulses.

Electrocardiogram shows sinus rhythm with mild resting sinus bradycardia at a rate of about 90 beats per minute with InSync dual-chamber pacing.

From overall evaluation, Wanda seems to be clinically stable and I have advised her to continue her current regimen including Lasix, potassium, Lanoxin, Norvasc, aspirin, calcium, Normodyne and Diovan. If you recall, she could not take Zestril because of a significant cough.

I plan to see her back in three months.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Rajendra C. Patel, MD, FACC
Dictated, but not read.
RCP/bjj

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
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Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

August 3, 2001

Choo Rhee MD
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn (DOB: 12/11/52)

Dear Choo:

Ms. Glenn was back in our office today for cardiac follow-up. As you know, she is a 48-year-old female with a history of dilated cardiomyopathy and now has an ICD in place along with biventricular pacing. Since her last visit she has had some social problems at home and is now going to divorce. Recently she has noted increasing fatigue and tiredness as well as exercise intolerance. Fortunately, however, she denied any PND, orthopnea or leg edema.

Physical examination today in my office revealed no evidence of jugular venous distention or carotid bruits. Lungs were bilaterally clear. Cardiac auscultation revealed a regular rhythm with an impressive S4 gallop. Abdomen and extremities were unremarkable. Blood pressure was 140/90.

Apparently she could not tolerate Zestril because of cough and she is now on Diovan.

From my standpoint she looks clinically well compensated. However, I am concerned about her increasing general fatigue which could be from all her psychosocial problems or there could be some involvement of her cardiac status causing her symptoms. At this stage, however, I have reassured her that I do not see any overt congestive heart failure. My inclination would be to see her back in three months. Depending on her clinical status at that time, we might consider another ultrasound to make sure that the LV function is not getting worse. I will keep you posted regarding her progress.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Rajendra C. Patel, MD, FACC
Dictated, but not read.
RCP/bjj

MetLife
Attending Physician's Statement of Functional Capacity

MetDisAbility
P.O. Box 3043
Utica, NY 13504-3043

The information provided is to be used for claims evaluation and auditing purposes only.
The patient is responsible for having this form completed without expense to Metropolitan or the Employer.

Patient Name		
First	Middle	Last
WANDA		GLENN
Group Number 0031003		
Social Security # [OMITTED]		

1. History and Diagnosis
   - A. Date symptoms first appeared/or accident occurred: 02-1-00
   - B. Date patient ceased work: 04-30-00
   - C. Date of most recent examination: 11-2-01
   - D. Frequency of visits: 2-3 months
   - E. Past history:
   - F. Subjective symptoms:
   - G. Objective findings (including test results):
   - H. Primary diagnosis affecting work ability:

     CMP – Idiopathic, SOB, fatigue, CHF,

Hypertension

I. Secondary diagnosis affecting work ability:

J. Present and future course of treatment:

K. Other known injuries or presently active diseases that may affect work abilities:

2. Does patient's medical condition allow exposure to the following; please check appropriate box and explain any limitation below:

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Dust/Gasses/Fumes				
Chemicals/Solvents				
Temperature Extremes		See Attached		
Noise Levels				
Allergenic Agents				
Stairs/Ladders				
Scaffolds/Heights				
Enclosed Spaces				
Drafts/Damp Areas				

Explanation:

---

3. Because of the patient's medical conditions, are there any limitations on any of the following activities; please check appropriate box and explain any limitation below:

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Transportation				
Standing				
Sitting				
Change of Position (sitting/standing)				

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Assuming Cramped/Unusual Positions				
Reaching (forward/overhead)				
Pushing/Pulling/Twisting (arm/leg controls)		See Attached		
Grasping/Handling				
Finger Dexterity				
Repetitive Movement (hands/feet)				
Climbing (stairs/ladders/scaffolds)				
Balancing (exposure to falling)				
Bending/Stooping/Squatting				
Operating Truck/Dolly/Small Vehicle				
Operating Heavy Equipment				
Operating Electrical Equipment				
Concentrated Visual Attention				
Other				

Explanation:

---

4. Evaluation of carrying and lifting abilities includes both the intensity and frequency of the activity. For each weight class listed below, please indicate the reasonable top limit of frequency. Please provide an explanation below

with any additional comments regarding limitations on duration, handlability and distance (in front of body and above floor).

Intensity in Pounds	Frequency: Percentage of Workday			
	Never	Less than 20%	20% - 60%	Greater than 60%
0-15	√			
16-30				
31-45				
Greater than 45				

Explanation:

---

5. Is there a past or present psychological problem that might interfere with the patient's ability to work? If yes, please list your findings according to the DMS-tti multiaodal classification.

Yes ☐ No ☐ Not Determined ☐

Explanation: See attached

---

6. If you have any additional information that is relevant to patient's work ability, please indicate below.

See attached

---

7. Progress Evaluation

☐ Recovered ☐ Improved ☐ Unimproved
☐ Retrogressed

(Please check appropriate box and explain below:)

Explanation:

8. Disability Evaluation

Is patient now totally disabled?

For Any Occupation			For His/Her Occupation		
Yes ☒	No ☐	Cannot Determine ☐	Yes ☐	No ☒	Cannot Determine ☐

If No, when was patient able to resume work activities?

For Any Occupation		For His/Her Occupation	
_____	Cannot Determine ☐	_____	Cannot Determine ☐

If Yes, when do you think patient will be able to resume work activities:

	For Any Occupation	For His/Her Occupation
Approximate Date:	Never	
Indefinite:		
Never:		
Cannot Determine:		

Raj Patel	MD		
Name of Physician	Board Certified Specialty		
423 E. Town St	Cols. OH	43215	
Street Address	City or Town	State	
(614) 464-0884		/s/	12/19/01
Telephone Number	Date	Signature	

CAPITOL CITY CARDIOLOGY
Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
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Charles W. Noble, II, MD
Rajendra C. Patel, MD

April 6, 2001

Choo Y. Rhee, M.D.
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn (DOB: 12/11/52)

Dear Choo:

Ms. Glenn was in our office today, earlier than expected. As you know, she is a 48-year-old female with dilated cardiomyopathy, complex ventricular arrhythmias, and an ICD in place. The recent ICD change was combined with biventricular pacing, which is a new technique for patients with cardiomyopathy to improve the synchronized left ventricular wall motion. Ms. Glenn came in earlier to see us because she has been experiencing some general fatigue. Interestingly enough, she says that she is doing more than before; however, after she has done an activity, she feels tired for a day or so. Apparently she used to only walk two laps at the mall, and now she is walking four or more laps. She is also walking four or five times a week, rather than two to three times a week. She denies any exertional

angina, excessive shortness of breath, paroxysmal nocturnal dyspnea or orthopnea.

Physical examination revealed no jugular venous distention or carotid bruits. Lungs are bilaterally clear. Cardiac auscultation reveals regular rhythm with an S4 gallop. Abdomen and extremities are unremarkable. Blood pressure was 148/98.

Ms. Glenn was extremely concerned about her LV function and we did do a 2D echocardiogram on her, and this showed an left ventricular ejection fraction anywhere from 40% to 50%, which is much better than 30% which was seen on previous studies.

I am not sure whether the biventricular pacing has improved her ejection fraction, or whether she is clinically improving spontaneously. At the present time I have reassured her regarding the absence of any deterioration, and I have explained that her ejection fraction looks slightly better. I have advised her to continue her activity at the current level, trying to gradually increase it; however, she should not push herself beyond her limit.

I plan to see her back now in four months, and I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/

Rajendra C. Patel, MD, FACC
Dictated, but not read.
RCP/cjm

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
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Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

ECHOCARDIOGRAPHIC REPORT

Test Date: March 28, 2001

Patient Name: Wanda Glenn

Ref. Physician: Rajendra C. Patel, MD

Patient History: Idiopathic cardiomyopathy with Implantable defibrillator

2D: ☒ M-Mode: ☒ Doppler: ☒

Tape #: 10

Age: 48

PCP: Choo Rhee, MD

Wt:

Ht:

Echocardiographic Measurement:

Aortic Root	–	3.5	(2.0-4.0)
AoV Opening	–	2.0	(1.5-2.6)
Lt. Atrium	–	3.2	(1.9-4.0)
Pl. Effusion	–		

Sm. ☐ Mod. ☐ Lg. ☐

RVD	–	1.9	(0.9-2.6)
IVS	–	1.1	(0.7-1.1)
LVD	–	5.2	(<5.6)
LVS	–	3.2	(<3.5)
LVPW	–	1.1	(0.7-1.1)
RVSP	–		mm/Hg.
HR	–	106	BPM
EF	–	40	%

Interpretation:

The indication for this study is to evaluate a cardiomyopathy.

Standard 2-D, pulse, continuous wave and color-flow echocardiography were performed. The study is technically good. There is no pericardial effusion. Both atria are normal. The tricuspid, mitral and aortic valves are structurally normal. There is a catheter in the right ventricle which is probably a pacemaker. There is an echogenic area running across the tricuspid valve annulus which may be a coronary sinus catheter. The left ventricle has a normal diastolic dimension and normal wall thickness. Systolic function is at the lower limits of normal. I put it at 45-50%. In one view it appears that the inferior base is akinetic. Doppler evaluation reveals normal function in the mitral, tricuspid and aortic valves. Mitral diastolic flow is consistent with diastolic dysfunction.

CONCLUSION: This study demonstrates evidence of mildly reduced ejection fraction.

Technician /s/ David Cowles, BS, RDCS

Cardiologist /s/ Bruce L. Auerbach, MD, FACC

CAPITOL CITY CARDIOLOGY

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Richard M. Bardales, MD
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Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

December 15, 2000

Choo Y. Rhee, MD
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn (DOB: 12/11/52)

Dear Choo:

Ms. Glenn was back in our office today for cardiac follow-up. As you know, she is a 48-year-old female with dilated cardiomyopathy as well as complex ventricular arrhythmias and diabetes. She continues to have good days and bad days; however, mostly she is remaining out of any significant failure. Recently her ICD was revised and now she has an ICD with three leads and biventricutar pacing, which is a new technique for patients with cardiomyopathy. She does feel slightly different in terms of how her hearts beats; however, she remains free of any excessive shortness of breath, paroxysmal nocturnal dyspnea, or orthopnea.

Physical examination in my office showed no jugular venous distention or carotid bruits. Lungs were bilaterally clear. Cardiac auscultation revealed

regular rhythm with an S4 gallop. Abdomen and extremities are unremarkable. Electrocardiogram showed an interesting EKG of biventricutar pacing with beat tracking.

From overall evaluation, it seems Ms. Glenn is doing clinically well. In the absence of any new symptoms I have advised her to return in six months for follow-up. If you recall, she also follows up with Dr. Carl Leier once a year for her dilated cardiomyopathy and she sees Dr. Charles Love at Ohio State University for her pacemaker follow-up.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Rajendra C. Patel, MD, FACC
Dictated, but not read.
RCP/sem

MetLife
Attending Physician's Statement of Functional Capacity

Met DisAbility
P.O. Box 3043
Utica, NY 13504-3043

The information provided is to be used for claims evaluation and auditing purposes only.
The patient is responsible for having this form completed without expense to Metropolitan or the Employer.

Patient Name First	Middle	Last
WANDA		GLENN
Group Number 0031003		
Social Security # [OMITTED]		

1. History and Diagnosis
   - A. Date symptoms first appeared/or accident occurred: 02-1-00
   - B. Date patient ceased work: 04-30-00
   - C. Date of most recent examination: 07-28-00
   - D. Frequency of visits: every 3 months
   - E. Past history:
   - F. Subjective symptoms:
   - G. Objective findings (including test results):
   - H. Primary diagnosis affecting work ability:

     CMP – Idiopathic, SOB, Fatigue
   - I. Secondary diagnosis affecting work ability:

J. Present and future course of treatment:

K. Other known injuries or presently active diseases that may affect work abilities:

2. Does patient's medical condition allow exposure to the following; please check appropriate box and explain any limitation below:

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Dust/Gasses/Fumes				
Chemicals/Solvents				
Temperature Extremes		See Attached		
Noise Levels				
Allergenic Agents				
Stairs/Ladders				
Scaffolds/Heights				
Enclosed Spaces				
Drafts/Damp Areas				

Explanation:

3. Because of the patient's medical conditions, are there any limitations on any of the following activities; please check appropriate box and explain any limitation below

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Transportation				
Standing				
Sitting				
Change of Position (sitting/standing)				
Assuming Cramped/Unusual Positions				

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Reaching (forward/overhead)				
Pushing/Pulling/Twisting (arm/leg controls)		See Attached		
Grasping/Handling				
Finger Dexterity				
Repetitive Movement (hands/feet)				
Climbing (stairs/ladders/scaffolds)				
Balancing (exposure to falling)				
Bending/Stooping/Squatting				
Operating Truck/Dolly/Small Vehicle				
Operating Heavy Equipment				
Operating Electrical Equipment				
Concentrated Visual Attention				
Other				

Explanation:

---

4. Evaluation of carrying and lifting abilities includes both the intensity and frequency of the activity. For each weight class listed below, please indicate the reasonable top limit of frequency. Please provide an explanation below with any additional comments regarding limitations on duration, handlability and distance (in front of body and above floor).

Intensity in Pounds	Frequency: Percentage of Workday			
	Never	Less than 20%	20% - 60%	Greater than 60%
0-15	√			
16-30				
31-45				
Greater than 45				

Explanation:

---

5. Is there a past or present psychological problem that might interfere with the patient's ability to work? If yes, please list your findings according to the DMS-tti multiaodal classification.

Yes ☐ No ☐ Not Determined ☐

Explanation: See attached

---

6. If you have any additional information that is relevant to patient's work ability, please indicate below.

See attached

---

7. Progress Evaluation

☐ Recovered ☐ Improved ☐ Unimproved
☐ Retrogressed

(Please check appropriate box and explain below:)

Explanation:

8. Disability Evaluation

Is patient now totally disabled?

For Any Occupation			For His/Her Occupation		
Yes ☒	No ☐	Cannot Determine ☐	Yes ☐	No ☒	Cannot Determine ☐

If No, when was patient able to resume work activities?

For Any Occupation		For His/Her Occupation	
_____	Cannot Determine ☐	_____	Cannot Determine ☐

If Yes, when do you think patient will be able to resume work activities:

	For Any Occupation	For His/Her Occupation
Approximate Date:	Never	
Indefinite:		
Never:		
Cannot Determine:		

Raj Patel	MD	
Name of Physician	Board Certified Specialty	
423 E. Town St.	Cols. OH	43215
Street Address	City or Town	State
(614) 464-0884	11/20/00	/s/
Telephone Number	Date	Signature

CAPITOL CITY CARDIOLOGY

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Charles W. Noble, II, MD
Rajendra C. Patel, MD

April 7, 2000

Choo Y. Rhee, M.D.
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn

Dear Choo:

Ms. Glenn was back in our office today for cardiac follow-up. As you know, she underwent coronary angiography at Grant Medical Center which showed evidence of primary dilated cardiomyopathy with an LV ejection fraction now of about 20-25%. She was started on Zestril 5mg. po qd which she is tolerating well. She continues to be generally fatigued and has some exertional shortness of breath. She denies any paroxysmal nocturnal dyspnea, orthopnea or leg edema. Her main problem now is the stress at work. She works in a Sears ~~catalog~~ store and does have physical as well as psychologic stress. Considering her low ejection fraction, I feel that she may not be able to continue to work in any kind of environment that would cause any significant physical or psychologic stress and demands.

At the present time I have advised her to try for disability. I have also advised her to increase the Zestril dose to 10mg. a day. I have advised her to get a chem-7 study done in about a week to make sure that she is tolerating the ACE inhibitor well without any electrolyte disturbances. Down the road my inclination would be to increase the Zestril dose to about 20mg. a day as tolerated. She is already on a beta blocker (Normodyne) and Lanoxin. She was seen by Dr. Charles Love at Ohio State University for her pacemaker follow-up, and he is planning to refer her to the cardiomyopathy clinic at Ohio State University Hospitals.

From a cardiac standpoint, I plan to see her back in a couple of months; however, depending on where she goes for her cardiac follow-up, I will decide whether I will be continuing to see her on a regular basis.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Raj. C. Patel, MD, FACC
Dictated, but not read.
RCP/cjm

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
River View Medical Office * 2405 North Columbus Street, Suite 130 * Lancaster, Ohio 43130 * 740-653-7511 * Fax 740/653-7512

Bruce L. Auerbach, MD
Richard M. Bardales, MD
Barney B. Beaver, DO
Reuben A. Sheares, III, MD
Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

July 28, 2000

Choo Y. Rhee, M.D.
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn

Dear Choo:

Ms. Glenn was back in our office today for cardiac follow up. As you know, she is a 47-year-old female with a history of idiopathic dilated cardiomyopathy as well as complex ventricular arrhythmias requiring a defibrillator. She has been evaluated by Dr. Carl Leier because of progressive LV dysfunction regarding the possibility of a cardiac transplant if needed. Fortunately, she showed good functional capacity and tolerance at the non-invasive workup at Ohio State University Hospital and at the present time has been under surveillance by Dr. Carl Leier. He is planning to see her once a year. Ms. Glenn still wants me to be her primary cardiologist. She basically has felt much better since last visit. I feel some of her improvement is from the reduction of stress and strain of work. She still has good and bad days and in fact there are periods where she feels

extremely tired and fatigued and runs out of steam. She fortunately, denies any paroxysmal nocturnal dyspnea, orthopnea or leg edema. Recently, she was seen in your office because of significant non-productive cough which possibly was related to Zestril and since then has been switched to Diovan. Other medications include Lasix, potassium, Lanoxin, Norvasc, aspirin and calcium as well as Normodyne.

Her physical examination today in my office reveled no evidence of jugular venous distention or carotid bruits. Lungs are bilaterally clear. Cardiac auscultation revealed regular rhythm with an S4 gallop. Abdomen was benign. Extremities reveal no ankle edema no acute distress good pedal pulses.

From overall evaluation it seems Wanda is doing clinically well. I have advised her now to return in four months for re-evaluation. Meanwhile, I have advised her to look for a permanent defibrillator considering her significant LV dysfunction. She will also be seeing Dr. Carl Leier once a year for her progressive myocardial disease.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/

Raj. C. Patel, MD, FACC
Dictated, but not read.
RCP/cb

CAPITOL CITY CARDIOLOGY

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Rajendra C. Patel, MD

April 28, 2000

Choo Y. Rhee, M.D.
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn

Dear Choo:

Ms. Glenn was back in our office today for cardiac follow up. She has been tolerating her Zestril well. Her chem 7 looked okay. I have now decided to increase her Zestril to 20 mg a day since her blood pressure today was 150/100. As you know, the other medications include Lasix, potassium supplement, Lanoxin and Norvasc as well as Normodyne. Ms. Glenn had multiple questions about her activity level and role of exercise program. I explained to her that aerobic type of exercises will definitely help her cardiovascular condition and in fact if her insurance company would approve it would be best for her to join a cardiac rehabilitation program for her dilated cardiomyopathy. I also answered some of her questions regarding her prognosis. I explained to her that prognosis in this condition is quite variable and it depends on the progression of her disease.

Periodic 2D echocardiographic studies as well as clinical evaluation will help to evaluate her progress. Ms. Glenn is planning to go to Ohio State for further evaluation of her cardiomyopathy and I agree with the plan.

From cardiac standpoint, I have advised her to see me back in three months, however, if she decides to have all her care taken at Ohio State University Cardiology Group, I would have no problems with this. I have advised her to have them contact me if I could provide any further details regarding her previous history.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Raj. C. Patel, MD, FACC
Dictated, but not read.
RCP/cb

CAPITOL CITY CARDIOLOGY

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Michael J. Meloca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

April 19, 2000

RE: Wanda Glenn

TO WHOM IT MAY CONCERN:

Ms. Wanda Glenn is a patient of mine who suffers from severe dilated cardiomyopathy. This patient has significant difficulty with general fatigue and exertional shortness of breath because of her cardiac condition.

From my standpoint, this patient cannot return to any kind of job that would require any significant physical or psychologic demands on her.

Please do not hesitate to call me if I can provide any further information in this matter. With best regards.

Sincerely,

/s/
Raj. C. Patel, MD, FACC
Dictated, but not read.
RCP/bjj

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
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Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD

March 13, 2000

Choo Rhee, MD
1492 E Broad St
Columbus OH 43205

RE: Wanda Glenn

Dear Choo:

Ms. Glenn was back in our office today for cardiac follow-up. Her adenosine cardiolite study did not show any inducible ischemia, however, it did show a fixed anterior defect which could be from breast attenuation, or it could represent an area of severe ischemia or infarction. Also, her ejection fraction was as low as about 22%, which is markedly reduced compared to her ejection fraction in the past which has been as high as 40-45%. Wanda had another episode of chest tightness while coming to our office. She describes continued difficulty with exertional chest tightness.

I advised her to undergo coronary angiography, particularly because of the progression of her LV dysfunction as well as continued symptoms. She has agreed with this. I had a lengthy discussion with her and her husband regarding the pros and cons of such

a procedure along with the risks and possible complications.

I will keep you posted regarding the cardiac catheterization findings, and then make additional recommendations as needed. I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Raj. C. Patel, MD, FACC
Dictated, but not read.
RCP/cjm

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
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Rajesh D. Gagiani, MD
Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajendra C. Patel, MD
Reuben A. Sheares, III, MD

March 15, 2000

Choo Y. Rhee, MD
1492 E Broad St #1604
Columbus OH 43205

RE: Wanda Glenn

Dear Choo:

Ms. Glenn underwent coronary angiography which basically showed normal coronary angiography with no evidence of coronary obstructive disease. Left ventricular cineangiography showed severe dilated cardiomyopathy with an ejection fraction of about 20-25%. She was started on Zestril (5 mg) po qd as an ACE inhibitor along with her other medications, and I will titrate this ACE inhibitor dose as tolerated.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/
Raj. C. Patel, MD, FACC
Dictated, but not read.
RCP/tjs

CAPITOL CITY CARDIOLOGY

Main Office * 423 East Town Street * Columbus, Ohio 43225 * Phone 814/444-0884 800/479-6802* Fax 614/464-3440
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Rajesh D. Gaglani, MD
Michael J. Meleca, MD
Charles W. Noble, II, MD
Rajandra C. Patel, MD
Reuben A. Sheares, III, MD

March 3, 2000

Choo Y. Rhee, M.D.
1492 E Broad St #1604
Columbus, OH 43205

RE: Wanda Glenn

Dear Choo:

Ms. Glenn was back in our office today for cardiac follow-up. As you know, she is a 47-year-old female with history of sudden cardiac death syndrome, chronic left bundle branch block, and primary myocardial disease, moderate LV systolic dysfunction and normal coronary angiography. She had a cardiac catheterization in 1993. She has an ICD device which is being followed up by Dr. Love at Ohio State University Hospital. Ms. Glenn has been clinically stable on medical regimen and has not seen me for awhile. She now returns to see me because of concerns about substernal chest tightness. The chest tightness is in the form of vague heavy pressure which lasts several hours at a time, not always related to exertion or emotional excitement. Episodes come and go however they have become a little more frequent and concerning to her. She

denies any exertional shortness of breath, paroxysmal nocturnal dyspnea or orthopnea. She denies any dizziness or syncope.

Current medications include Lasix, potassium supplement, Lanoxin, Norvasc, aspirin, Normodyne, as well as calcium supplement. She does not smoke and denies any alcohol overuse.

Physical examination revealed a 47-year-old female with normal physical build. She is warm and dry. There is no jugular venous distention or carotid bruits. Lungs were bilaterally clear. Cardiac auscultation revealed regular rhythm with an S4 gallop. Abdomen was benign. Extremities revealed no ankle edema and good pedal pulses. Electrocardiogram shows chronic left bundle branch block with secondary ST changes. The EKG is unchanged from previous tracings.

From overall evaluation it seems Ms. Glenn is having difficulty with recurrent chest pains, chest tightness and pressure. I am not sure whether we are dealing with ischemic heart disease or whether this is non-cardiac chest discomfort. Considering her dilated cardiomyopathy and chronic left bundle branch block, I have decided to do a 2D echocardiogram and Adenosine Cardiolite study to evaluate this situation further, and depending on the findings, I will make additional recommendations regarding coronary angiography or medical management.

I deeply appreciate the opportunity to participate in her care.

Sincerely,

/s/

Raj. C. Patel, MD, FACC
Dictated, but not read.
RCP/tjs

MetLife
Attending Physician's Statement of Functional Capacity

Met Disability
P.O. Box 3043
Utica, NY 13504-3043

The information provided is to be used for claims evaluation and auditing purposes only. The patient is responsible for having this form completed without expense to Metropolitan or the Employer.

Patient Name First	Middle	Last
WANDA		GLENN
Group Number 0031003		
Social Security # [OMITTED]		

1. History and Diagnosis
   - A. Date symptoms first appeared/or accident occurred: 02-01-00
   - B. Date patient ceased work: 04-30-00
   - C. Date of most recent examination: 04-06-01
   - D. Frequency of visits: Q 3 months
   - E. Past history:
   - F. Subjective symptoms:
   - G. Objective findings (including test results):
   - H. Primary diagnosis affecting work ability:

     CMP – Idiopathic, SOB, Fatigue

I. Secondary diagnosis affecting work ability:

J. Present and future course of treatment:

K. Other known injuries or presently active diseases that may affect work abilities:

2. Does patient's medical condition allow exposure to the following; please check appropriate box and explain any limitation below:

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Dust/Gasses/Fumes				
Chemicals/Solvents				
Temperature Extremes		See Attached		
Noise Levels				
Allergenic Agents				
Stairs/Ladders				
Scaffolds/Heights				
Enclosed Spaces				
Drafts/Damp Areas				

Explanation:

---

3. Because of the patient's medical conditions, are there any limitations on any of the following activities; please check appropriate box and explain any limitation below.

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Transportation				
Standing				
Sitting				
Change of Position (sitting/ standing)				

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Assuming Cramped/Unusual Positions				
Reaching (forward/overhead)				
Pushing/Pulling/ Twisting (arm/leg controls)		See Attached		
Grasping/Handling				
Finger Dexterity				
Repetitive Movement (hands/feet)				
Climbing (stairs/ladders/scaffolds)				
Balancing (exposure to falling)				
Bending/Stooping/Squatting				
Operating Truck/Dolly/Small Vehicle				
Operating Heavy Equipment				
Operating Electrical Equipment				
Concentrated Visual Attention				
Other				

Explanation:

---

4. Evaluation of carrying and lifting abilities includes both the intensity and frequency of the activity. For each weight class listed below, please indicate the reasonable top limit of frequency. Please provide an explanation below with any additional comments regarding

limitations on duration, handlability and distance (in front of body and above floor).

Intensity in Pounds	Frequency: Percentage of Workday			
	Never	Less than 20%	20% - 60%	Greater than 60%
0-15	√			
16-30				
31-45				
Greater than 45				

Explanation:

---

5. Is there a past or present psychological problem that might interfere with the patient's ability to work? If yes, please list your findings according to the DMS-tti multiaodal classification.

Yes ☐ No ☐ Not Determined ☐

Explanation: See attached

---

6. If you have any additional information that is relevant to patient's work ability, please indicate below.

See attached

---

7. Progress Evaluation

☐ Recovered ☐ Improved ☐ Unimproved
☐ Retrogressed

(Please check appropriate box and explain below:)

Explanation:

8. Disability Evaluation

Is patient now totally disabled?

For Any Occupation			For His/Her Occupation		
Yes ☒	No ☐	Cannot Determine ☐	Yes ☐	No ☒	Cannot Determine ☐

If No, when was patient able to resume work activities?

For Any Occupation		For His/Her Occupation	
_____	Cannot Determine ☐	_____	Cannot Determine ☐

If Yes, when do you think patient will be able to resume work activities?

	For Any Occupation	For His/Her Occupation
Approximate Date:	Never	
Indefinite:		
Never:		
Cannot Determine:		

Raj Patel	MD		
Name of Physician	Board Certified Specialty		
423 E. Town St.	Cols. OH	43215	
Street Address	City or Town	State	
(614) 464-0884		/s/	6/27/01
Telephone Number	Date	Signature	

TRANSFERABLE SKILLS ANALYSIS

CLAIMANT:	Wanda Glenn
CLAIM #:	690008108949
SOCIAL SECURITY #:	[OMITTED]
DOB:	12/11/52
GROUP #:	31003
D.O.D:	4/30/2000
EMPLOYER:	Sears
REFERRED BY:	Earl Chesler
DATE:	July 10, 2002
CONSULTANT:	Lisa Hissem, MS, CRC

INTRODUCTION

Ms. Glenn is a fifty year old Sales Department Manager for Sears, Roebuck & Co. who has been out of work since April 30, 2000. She is diagnosed with Cardiomyopathy. Ms. Glenn's current Monthly Long-Term Disability benefit is $1,850.00. Ms. Glenn has been employed by Sears Roebuck & Co since March of 1990 and annual salary is $36,999.96. A Transferable Skills Analysis and Labor Market Analysis was requested and completed using the Dictionary of Occupational Titles (DOT), the Occupational Access System (OASYS) and the America's Job Bank for the state of Ohio.

VOCATIONAL/EDUCATIONAL HISTORY

According to the Training, Education and Experience for Long Term Disability claim form, Ms. Glenn reported completing twelve years of education. Ms. Glenn worked at Sears, Roebuck & Co. as a Sales Department Manager, from 1994 to 2000, which involved maximizing store revenue and profit; identify and solve business problems; develop and maintain quality customer service; and hire, train and supervise staff. Additional responsibilities

include coordinate daily activities of sales department; monitor merchandise replenishment; and establish and communicate performance goals and standards. Ms. Glenn also worked as a Sales Associate from 1986 to 1994 and an Auditing Clerk from 1988 to 1989.

Ms. Glenn's vocational training and work experience can best described by the following descriptions from the Dictionary of Occupational Titles:

Title	DOT#
Manager, Department Store	185.117-010
Manager, Sales	163.167-018
Sales Representative, General Merchandise	279.357-014
Audit Clerk	210.382-010

The physical demand categories for these occupations are sedentary to light according to the Department of Labor (DOL). A Department Store Manager is considered to be a skilled occupation requiring over four years and up to ten years of training to acquire the skills and knowledge necessary to perform the job at an average level of competence.

MEDICAL HISTORY-RESTRICTIONS AND LIMITATIONS

Physical restrictions and limitations were obtained from the Attending Physician Statement, dated June 12, 2002, by Dr. Rajendra Patel. Dr. Patel indicates that Ms. Glenn is capable of a sitting for eight hours, standing for four hours, walking for two to four hours; ability to lift and carry up to ten pounds occasionally; ability to perform bilateral upper extremity movements; ability to bend and squat frequently; inability to crawl, climb, being

around unprotected heights and moving machinery. Dr. Patel also notes additional restrictions and limitations as 'no emotional stress and heavy exertion'.

An Independent Physician Consultation indicates the above restrictions and limitations are appropriate given the diagnosis and level of functioning.

Based on this information it is determined that Ms. Glenn capable of Sedentary Exertion Level activity defined by the U.S. Department of Labor. Sedentary Level is defined as "Exerting up to ten pounds of force occasionally and /or a negligible amount of force frequently to lift, carry push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met."

TRANSFERABLE SKILLS ANALYSIS

Alternative occupations were identified using the OASYS software program (Version 1.30, 2000). This search identifies occupations that are consistent with Ms. Glenn's Specific Vocational Preparation, General Education Development, physical capabilities and required skills she has demonstrated the ability to perform in her past work experience. Occupations listed in the DOT are based on the DOL's standard criteria, as performed in the general labor market. The following jobs were among those identified:

Title	DOT#	Exertion Level	Estimated Monthly Wages
1. Account Information Clerk	210.367-010	Sedentary	$ 2,116.66
2. Attendance Clerk	219.362-014	Sedendary	$ 1,768.33
3. Classified Ad Clerk	247.367-010	Sedentary	$ 1,950.00

LABOR MARKET ANAYSIS

The estimated wages given are based on OASYS wage information obtained from the Bureau of Labor Statistics utilizing Occupational Employment Statistics (OES) as its basis. Utilizing Americas Job Bank to match industry codes with those most likely to hire for these occupations identified, employers were noted to exist with Ms. Glenn's geographical area of Columbus, Ohio.

CONCLUSION

Ms. Glenn is a fifty year old Sales Department Manager for Sears, Roebuck & Co. who has been out of work since April 30, 2000. She is diagnosed with Cardiomyopathy. The Attending Physician statement has noted restrictions and limitations that match the Sedentary Physical Exertion Level as defined by the U.S. Department of Labor. Alternative occupations that she has demonstrated the transferable skills to perform within her residual physical capacities were identified. Employers from the industries most likely to hire for these occupations were noted to exist in Ms. Glenn's geographical area of Columbus, Ohio.

Respectfully submitted,

/s/
Lisa Hissem, MS, CRC
Vocational Rehabilitation Consultant

Attending Physician's Statement of Functional Capacity

Mail this form to Sears in the self addressed envelope.

It is a crime to fill out this form with facts you know are false or to leave out facts you know are important.

The information provided is to be used for claims evaluation and auditing purposes only. The patient is responsible for having this form completed without expense to Metropolitan or the Employer.

1. History and Diagnosis
   - A. Date symptoms first appeared/or accident occurred: 3-3-2000
   - B. Date patient ceased work: 4/30/2000
   - C. Date of first visit:
   - D. Date of most recent examination: 7-28-2000
   - E. Frequency of visits: every 3 months
   - F. Past history:
   - G. Objective findings including test results:
   - H. Subjective symptoms: see attached
   - I. State primary diagnosis affecting work ability:
   - J. State secondary diagnosis affecting work ability: See attached
   - K. Present and future course of treatment:
   - L. Other known injuries or presently active diseases that may affect work abilities:

M. Surgery:	Performed — Date 3/14/00 Anticipated — Date

2. Does patient's medical condition allow exposure to the following; please check appropriate box and explain any limitation below.

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Dust/Gasses/Fumes				
Chemicals/Solvents				
Temperature Extremes		See Attached		
Noise Levels				
Allergenic Agents				
Stairs/Ladders				
Scaffolds/Heights				
Enclosed Spaces				
Drafts/Damp Areas				

Explanation:

---

3. Because of the patient's medical conditions, are there any limitations on any of the following activities? Please check appropriate box and explain any limitation below:

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Commuting: (a) Ability to drive (b) Use of public transportation				
Walking				
Standing				
Sitting				
Change of Position (sitting/standing)				

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Assuming Cramped/Unusual Positions				
Reaching (forward/overhead)				
Pushing/Pulling/ Twisting (arm/leg controls)		See Attached		
Grasping/Handling				
Finger Dexterity				
Repetitive Movement (hands/feet)				
Climbing (stairs/ladders/scaffolds)				
Balancing (exposure to falling)				
Bending/Stooping/ Squatting				
Operating Truck/Dolly/Small Vehicle				
Operating Heavy Equipment				
Operating Electrical Equipment				
Concentrated Visual Attention				
Other				

Explanation:

4. Evaluation of carrying and lifting abilities includes both the intensity and frequency of the activity. For each weight class listed below, please indicate the reasonable top limit of frequency. Please provide an explanation below with any additional comments regarding

limitations on duration, ability to handle and distance (in front of body and above floor)

Intensity in Pounds	Frequency: Percentage of Workday			
	Never	Less than 20%	20% - 60%	Greater than 60%
0-15	√			
16-30				
31-45				
Greater than 45				

Explanation:

See attached

---

5. Is there a past or present psychological problem that might interfere with the patient's ability to work? If yes, please list your findings according to the DMS-tti multiaodal classification.

Yes ☐ No ☒ Not Determined ☒

---

6. Indicate below if you have any additional information that is relevant to this patient's work ability. Please refer to the questions on the front of this form regarding Job Description and, if necessary, discuss them with the patient.

See attached

---

7. Disability Evaluation – We are seeking your Medical opinion on this topic. It will be our responsibility to assess it against vocational data, such as level of earnings (and job availability.

The following questions take into account whether the patient can perform the important duties of his/her job with reasonable continuity, including commuting to work. They also take into account whether the patient can perform the important duties of any other job with reasonable continuity including commuting to work. In answering these questions please consider his/her age, physical capacities, education, training, and experience.

Is patient now totally disabled?

For His/Her Occupation			For Any Occupation		
Yes ☒	No ☐	Cannot Determine ☐	Yes ☐	No ☒	Cannot Determine ☒

If No, when was patient able to resume work activities?

For Any Occupation		For His/Her Occupation	
_____	Cannot Determine ☐	_____	Cannot Determine ☐

If Yes, when do you think patient will be able to resume work activities:

	For Any Occupation	For His/Her Occupation
Approximate Date:	_____	_____
Indefinite:	_____	_____
Never:	Never	_____
Cannot Determine:	_____	_____

If Yes, is patient a suitable candidate for:

(a) vocational rehabilitation Yes ☐ No ☐

(b) therapeutic rehabilitation Yes ☐ No ☐

---

8. Progress Evaluation

Recovered	Yes ☐	No ☐
Improved	Yes ☐	No ☐
Unimproved	Yes ☐	No ☐
Retrogressed	Yes ☐	No ☐

---

9. In your opinion is the patient competent to endorse checks and direct the use of their proceeds? Yes ☒ No ☐

---

10. Remarks: If you have additional information relative to this disability claim, please use page four.

Raj Patel	MD Cardiology	
Name of Physician	Board Certified Specialty	
423 E. Town St.	Columbus, OH	43215
Street Address	City or Town	State
(614) 464-0884	8/2/00	/s/
Telephone Number	Date	Signature

SEARS **MetLife**

Met Disability
P.O. Box 3043
Utica, NY 13504
Fax # 315-792-2514

EMPLOYER'S STATEMENT OF LTD CLAIM

FRONT SIDE TO BE COMPLETED BY THE ASC. REVERSE SIDE TO BE COMPLETED AND SIGNED BY THE UNIT MANAGER

Claimant's Full Name: Glenn, Wanda
Date of Birth: 12/11/52
Social Security No.: [OMITTED]
Service Date: 3-20-90
Employment Status:
Regular Hourly ☐
Part-Time Regular Hourly ☐
Salaried ☒
LTD Insurance Effective Date 4/1/91
Unit No 1370
Div/Dept 7003-A
ASC No 745166
Last Day Worked 4-29-00
☐ Hourly Current Hourly Benefit Rate _____
☒ Salaried Current Monthly Rate_____
Status:
☒ Active
☐ Terminated/Retired

_____
Date
☐ Date of Last Contribution _____
☐ Leave of Absence _____
☐ Type of Leave _____

BEST AVAILABLE COPY

☐ Date Leave Began _____

Medical Information: Include Copies of Any Medical Reports, etc. Relevant to Associate's Claim

If currently a member, period of time, if any, without insurance coverage or with suspended coverage From _____ To _____

If not currently a member, date of coverage termination _____

Long-Term Disability (LTD)

Current LTD monthly covered earnings $3,083.33

Other Disability Benefits – Always Complete This Section
For Associates covered by the disability plans of Rhode Island, New York, New Jersey, Puerto Rico, Hawaii and/or California, give amounts and dates of disability benefits under such plans received beyond 20 weeks.

Weekly Benefit $
Anticipated Expiration Date*
***If no expiration date show "continuing"**

Did the disability result from a work-related injury or illness? Yes No

Has a claim for workers compensation been filed? Yes No

If yes, provide address and telephone number of workers compensation claim office in space below

_____
_____
_____
_____
( ) _____

If a claim has been filed
Legal Rate Per Week $
Date Statutory Benefits Started _/_/_/
Date Statutory Benefits Terminated _/_/_/
If no termination date, show "continuing"

Attach a copy of all notices, agreements, awards and/or compromise settlements

Worked in State _____

Important: Store Manager Must Complete Associate's Job Description on Reverse Side

ASC Stamp

SEARS, ROEBUCK AND CO.
Associate Service Center
4740 Hugh Howell Rd.
Tucker, GA 30084

/s/
Signature of ASC Manager

7/11/00
Date

(770) 496-7800
Telephone No.

It is a crime to fill out this form with facts you know are false or to leave out facts you know are important

19081 Rev. 3/95 Sears Forms Management

(See Reverse Side)

CLAIMANT'S JOB DESCRIPTION

Name Glenn, Wanda	Regular Hourly ☐ Part-Time Regularly Hourly ☐ Salaried ☒
Job Title Manager 7003A	Present Assignment Date 3-20-90
Part-Time Regular Number of Hours Worked Per Week Prior to Disability 40-50	
CURRENT OCCUPATIONAL REQUIREMENTS Please check appropriate box to indicate current occupation requirements. When more than one exposure or activity is listed per line, cross out that which does not apply.	

Exposure to:	0%	1-19% Working Day	20%-60% Working Day	61%-100% Working Day
Dust/gas/fumes		X		
Chemicals/solvents		X		

Temperature extremes	X			
High nose levels	X			
Allergenic agents		X		
Enclosed spaces	X			
Wet conditions	X			
Reduced lighting levels	X			
Electrical sources	X			
Other				

Explanation:

Required Activities:	0%	1-19% Working Day	20%-60% Working Day	61%-100% Working Day
Sitting		X		
Standing			X	
Walking				X
Climb stairs/ladder/scaffold		X		
Balancing (Exposure to falling)		X		
Cramped/unusual positions	X			
Extended reach forward/overhead		X		
Push/pull/twist		X		
Grasp/handle		X		
Bend/stoop/squat		X		
hand dexterity		X		
Highly repetitive motion		X		
Forceful wrist twisting		X		
Operate truck/dolly/small vehicle	X			
Operate heavy equipment	X			
Fine visual auditory attention	X			
Precise verbal/ written communication	X			

Other				

Explanation:

Carrying & Lifting Requirements

Intensity in Pounds	Frequency: Percentage of Workday			
	Never	Less Than 20%	20%-60%	Greater Than 60%
0-15		X		
16-30		X		
31-45		X		
>45		X		

Explanation (if necessary):
Supervisory Functions (if applicable): Directly supervises 20-30 sales associates

Other Significant Factors or Comments:

/s/	Pat Butler	(614) 868-7094	7-2-00
Signature of Unit Manager	Print Name	Telephone	Date

KENNEDY & ASSOCIATES, INC.
P.O. Box 159
Tinley Park, Illinois 60477-0159
tel.: 800-637-0593 * fax: 708-532-7847
email: SSAAid@aol.com

July 8, 2002

Mr. Paul DePree
Metropolitan Life Insurance Co
Disability Management Services
P.O. Box 14590
Lexington, KY 40511-4590

Financial Index for Claim No: 690008108949

Re:	Glenn, Wanda
Claim #:	690008108949
SSN:	[OMITTED]
Group #:	31003
Group:	Sears

Dear Mr. DePree:

Social Security Award information for claimant was previously submitted. We are writing to advise of payment received from the claimant for our services.

Kennedy & Associates has received payment from Ms. Wanda Glenn for our services in securing her Social Security disability award.

The payment received was check number 3382 and the amount was $4,434.50.

As always, we greatly appreciate the opportunity to provide you insured with an effective means by which to secure their Social Security benefits, and we look forward to your future referrals.

Respectfully,
/s/
Maria Flores
Account Representative
Kennedy & Associates

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Office of Central Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241-1500
Date: June 15, 2002
Claim Number: [OMITTED]HA

WANDA GLENN
2566 SONATA DR
COLUMBUS, OH 43209-3211

You are entitled to monthly disability benefits beginning October 2000.

The Date You Became Disabled

We found that you became disabled under our rules on April 30, 2000.

However, you have to be disabled for 5 full calendar months in a row before you can be entitled to benefits. For these reasons, your first month of entitlement to benefits is October 2000.

What We Will Pay And When

- You will receive $17,738.00 around June 21, 2002.
- This is the money you are due for October 2000 through May 2002.
- Your next payment of $911.00, which is for June 2002, will be received on or about the third Wednesday of July 2002.

- After that you will receive $911.00 on or about the third Wednesday of each month.
- These and any future payments will go to the financial institution you selected. Please let us know if you change your mailing address, so we can send you letters directly.

The day we make payments on this record is based on your date of birth.

Enclosure(s):

Pub 05-10153
Pub 05-10058
Return Envelope
Form (HCFA-2690)

See Next Page

Your Benefits

The following chart shows your benefit amount(s) before any deductions or rour ding. The amount you actually receive(s) may differ from you full benefit amount. When we figure how much to pay you, we must deduct certain amounts, such as Medicare premiums. We must also round down to the nearest dollar.

Beginning Date	Benefit Amount	Reason
October 2000	$825.40	Entitlement began
December 2000	$854.20	Cost-of-Living adjustment
January 2001	$888.70	Credit for additional earnings
December 2001	$911.80	Cost-of-Living adjustment

Information About Medicare

You are entitled to medicare hospital and medical insurance beginning October 2002.

We will send you a Medicare card. You should take this card with you when you need medical care. If you need medical care before receiving the card and your coverage has already begun, use this letter as proof that you are covered by Medicare.

If you do not want medical insurance, please complete the enclosed card and return it to us in the envelope we have provided. You will need to do this by the date shown on the card. If you decide you do not want the insurance, we will return any premiums that you have paid.

Information About Representative's Fees

We have approved the fee agreement between you and your representative.

Your past-due benefits are $17,738.00 for October 2000 through May 2002. Under the fee agreement, the representative cannot charge you more than $4,434.50 for his or her work. The amount of the fee does not include any out-of-pocket expenses (for example, costs to get copies of doctors' or hospitals' reports). This is a matter between you and the representative.

How To Ask Us To Review The Determination On The Fee Amount

You, the representative or the person who decided your case can ask us to review the amount of the fee we say the representative can charge.

If you think the amount of the fee is too high, write us within 15 days from the day you get this letter. Tell us that you disagree with the amount of the fee and give your reasons. Send your request to this address:

Social Security Administration
Office of Hearings and Appeals
Attorney Fee Branch
5107 Leesburg Pike
Falls Church, Virginia 22041-3255

The representative also has 15 days to write us if he or she thinks the amount of the fee is too low.

If we do not hear from you or the representative, we will assume you both agree with the amount of the fee shown.

Other Social Security Benefits

The benefit described in this letter is the only one you can receive from Social Security. If you think that you might qualify for any other kind of Social Security benefit in the future, you will have to file another application.

Your Responsibilities

The decisions we made on your claim are based on information you gave us. If this information changes, it could affect your benefits. For this reason, it is important that you report changes to us right away.

We have enclosed a pamphlet, "When You Get Social Security Disability Benefits...What You Need To Know." It will tell you what must be reported and how to report. Please be sure to read the parts of the pamphlet which explain what to do if you go work or if your health improves.

A state or other public or private vocational rehabilitation provider may contact you to talk about their services. The rehabilitation provider may offer you counseling, training, and other services that may help you go to work. To keep getting disability benefits, you have to accept the services offered unless we decide you have a good reason for not accepting.

You do not have to wait to be contacted about vocational rehabilitation services. You can contact the nearest state vocational rehabilitation office directly and let them know that you are interested in receiving services.

If you go to work, special rules can allow us to continue your cash payments and health insurance

coverage. For more information about how work and earnings may affect disability benefits, you may call or visit any Social Security office. You may wish to ask for any of the following publications:

- Social Security – Working While Disabled...How We Can Help (SSA Publication No. 05-10095).
- Social Security – If You Are Blind—How We Can Help (SSA Publication No. 05-10050).
- How Social Security Can Help With Vocational Rehabilitation (SSA Publication No. 05-10052).

Other Information

We are sending a copy of this notice to THOMAS P PILIERO and DAVID B KENNEDY.

Do You Disagree With The Decision?

This action supersedes our previous determination and is in accordance with the decision on your hearing request. You have already been notified of your appeal rights regarding the decision made on your hearing request and what you must do to have that decision reexamined. If you want this reconsideration, you may request it through any Social Security office. If additional evidence is available, you should submit it with your request. We will review the case and consider any new facts you have. A person who did not make the first decision will decide your case. We will correct any mistakes. We will review those parts of the decision which you believe are wrong and will look at any new facts you have. We may also review those parts which you believe are correct and may make them unfavorable or less favorable to you.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You must have a good reason for waiting for more than 60 days to ask for an appeal.
- You have to ask for an appeal in writing. We will ask you to sign a Form SSA-561-U2, called "Request for Reconsideration". Contact one of our offices if you want help.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim". It contains more information about the appeal.

Things To Remember For The Future

Doctors and other trained staff decided that you are disabled under our rules. But, this decision must be reviewed at least once every 3 years. We will send you a letter before we start the review. Based on that review, your benefits will continue if you are still disabled, but will end if you are no longer disabled.

If You Have Any Questions

We invite you to visit our website at www.ssa.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-614-469-6850. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit

any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
4177 EAST BROAD STREET
COLUMBUS, OH 43213

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

/s/
Jo Anne B. Barnhart
Commissioner
Of Social Security

LIST OF EXHIBITS

Claimant: Wanda Glenn **SSN: [OMITTED]**

Exh. No	Part No.	Description	No. of Pages
		MEDICAL RECORDS	
1	F	Catherization Procedure Records dated 3-02-03 from OSU Hospital	3
2	F	Myocardial Perfusion Report dated 8-14-96 from OSU Heart Center	1
3	F	Stress test Report date 09-01-99 from OSU Heart Center	2
4	F	Clinic Medical Records covering the period from 6-2-00 to 7-11-00 from OSU Hospital	8
5	F	Medical Records covering the period from 3-03-00 to 8-04-00 from Raj C. Patel, M.D.	22
6	F	Medical Report dated 8-31-00 from Choo Y. Rhee, M.D.	5
7	F	Medical Report dated 9-14-00 from Carl Leier, M.D., OSU Center for Wellness & Prevention	6

Exh. No	Part No.	Description	No. of Pages
8	F	RFC – Residual Functional Capacity Assessment – Physical (completed by DDS physician) dated 11-04-00, Paul Dillahunt, M.D.	6
9	F	Medical Reords covering the period 9-27-00 to 12-15-00 from Rajendra C. Patel, M.D.	8
10	F	Medical Report dated 01-04-01 from Choo Y. Rhee, M.D.	3
11	F	Medical Records covering the period from 10/20/00 to 10/15/01 from Dr. Rajendra Patel	8
12	F	Medical Report dated 6-20-00 from Carl V. Leier, M.D.	3
13	F	Medical Report of ECG dated 7-11-00	2
14	F	Medical Report dated 9-27-00 from Pacemaker and Arrythjmia Services of The OSU Medical Center	1
15	F	Medical Report dated 10-11-00 from the Pacemaker and Arrythmia Services of the OSU Medical Center	3

Exh. No	Part No.	Description	No. of Pages
16	F	Medical Report dated 11-15-00 from the Pacemaker and Arrhythmia Services of the OSU Medical Center	1
17	F	Medical Report of Arrythmia Device Operation dated 2-28-01 from The Pacemaker Implant Department of OSU	2
18	F	Medical Report dated 4-11-01 from The Pacemaker and Arrthmia Services of the OSU Hospital	3
19	F	Medical Report dated 10-23-01 from The Pacemaker and Arrythmia Services of the OSU Medical Center	1
20	F	Medical Report dated 1-19-02 from The Pacemaker and Arrythmia Services of the OSU Medical Center	4
21	F	Medical Report dated 1-19-02 from Robert Hoover, M.D.	1
22	F	Medical Records dated 12/19/01 from Capitol City Cardiology, Dr. David Cowles	3
23	F	Medical Expert Analysis dated 3/13/02 from dr. Gordon Snider	1

KENNEDY & ASSOCIATES, INC.
P.O. Box 159
Tinley Park, Illinois 60477-0159
tel.: 800-637-0593 * fax: 708-532-7847
e-mail: SSAAid@aol.com

The Honorable Thomas P. Piliero
Administrative Law Judge
Office of Hearings and Appeals
280 N High St Room 300
Columbus, OH 43215

March 12, 2002

RE: Wanda Glenn
SS: [OMITTED]

Dear Judge Piliero:

This letter addresses the issues to be decided regarding the aforementioned individual's claim for Social Security Disability Insurance Benefits, and sets forth her representative's argument for a favorable decision on this claim. Ms. Glenn presents before Your Honor on Wednesday, March 13, 2002, at 1:00 p.m. I, Valerie C. Barich, a staff attorney with Kennedy and Associates, will be present to represent Ms. Glenn. To the best of my knowledge, and after due inquiry, all relevant medical information has been identified and submitted.

PROCEDURAL HISTORY

The claimant filed her application for Disability Insurance Benefits on August 11, 2000, alleging an onset date of April 30, 2000, due to severe dilated cardiomyopathy associated with extreme fatigue,

shortness of breath and tightness in the chest [Ex ID; 1 E/2]. She has no previous filings for disability benefits [Ex 2E/1], and her date last insured is December 31, 2004 [Ex 2E/1]. Her initial application and request for reconsideration were denied [Ex 1B/1; 3B/1], and the claimant's request for a hearing was timely filed [Ex 8E/1]. The claimant is scheduled for a hearing on March 13, 2002 at 1:00 p.m., and will be present with her representative.

VOCATIONAL HISTORY

Ms. Glenn is a forty-nine (49) year-old individual with 12 years of formal education resulting in a high school diploma [Ex 1E/8]; she was forty-seven (47) years old at her alleged onset date. She last held substantial gainful activity from September, 1994 through April 30, 2000, as a full-time sales manager of the women's clothing department within Sears, Roebuck, & Company [Ex 4E/1-2]. Her duties included overseeing daily operations of the department, identifying and solving business problems, and setting high merchandising and customer service standards [Id]. In this job, she frequently-to-constantly walked, occasionally-to-frequently stood and handled merchandise, and occasionally sat, climbed, stood, and wrote reports [Ex 3E/1-8]. She estimated that she frequently carried 10 pounds, but did carry and lift as much as 20 pounds. Prior to this, Ms. Glenn was employed from September, 1993 through September 1994, as a full time replenishment team leader with Sears. From September 1986 through September 1993, Ms. Green was employed with Sears as a part-time sales associate. In this position, she stood for 5 hrs, walked for one hour, frequently lifted 10 pounds, but lifted as much as 20 pounds [Ex 3E/1-8].

Simultaneous with this part-time position, Ms. Glenn was employed full-time as an auditing clerk from January, 1988 through September, 1989, and part-time as an educational aid from September, 1985 through September 1987, and again in September, 1989 [Id.]. Following exacerbation of her cardiac status by increased stress on the job, Ms. Glenn ceased working on April 30, 2000; This was the date she and her treating cardiologist, Dr. Patel, agreed she should discontinue working due to severe dilated cardiomyopathy that was worsening and interfering with her ability to perform her work duties.

MEDICAL HISTORY

The claimant's medical history is positive for hypertension, sudden cardiac death syndrome, chronic left bundle branch block, primary myocardial disease, and moderate LV systolic dysfunction with normal coronary angiography. Ms. Glenn has had significant systemic hypertension since 1984-1985 with antihypertensive therapy since that time [Ex 1F/1]; 4F/2]. In October, 1989, she survived sudden cardiac death [Ex 1F/1; 2F/1; 4F/2; 5F/2]. Catheterization at the time demonstrated normal coronary arteries with an overall ejection fraction of about 35 per cent [Ex 4F/2], and an AICD defibrillator system (epicardial pads) was surgically implanted. Its purpose was to prevent additional sudden death/malignant ventricular arrhythmia events, and maintenance of the device has been followed by Dr. Love [Ex 4F/2; 5F/2]. In 1993, the claimant began to experience chest pain and was hospitalized; Repeat catheterization again revealed normal coronary arteries, but also revealed global systolic dysfunction with an overall ejection fraction

of about 35 to 40 per cent [4F/2; 5F/2]. A left bundle branch block was discovered [Ex 2F/1), and she was hospitalized again in August 1996 for chest discomfort; In 1996, she had two defibrillator shocks that year, one while riding a bicycle and the other while performing a treadmill exercise test [4F/2-3].

In March, 2000, she returned to Raj C. Patel, MD, FACC, because of concerns about substernal chest tightness. Ms. Glenn described it as vague, heavy pressure lasting several hours at a time, and not always related to exertion or emotional excitement [Ex 5F/2]; While the episodes would come and go, they were occurring more frequently [Id.]. An electrocardiogram at that time showed chronic left bundle branch block with secondary ST changes [Id]. An Adenosine Cardiolite study revealed a fixed anterior defect and an ejection fraction as low as about 22 percent, a rate markedly reduced compared to past ejection fraction rates as high as 40-45 per cent [Ex 5F/3-5). Repeat catheterization in March, 2000, revealed patent coronary arteries, but an ejection fraction around 25 percent [Ex 4F/3]. Between March and June, 2000, Ms. Glenn reported increasing dyspnea on exertion, easy fatigability with increasing fatigue by the end of the day, and pedal edema with prolonged standing at work [Id.]. She was experiencing dyspnea going up two flights of stairs or walking about four blocks [Id.].

Because of the claimant's progressive LV dysfunction, Dr. Patel, the primary cardiologist, referred Ms. Glenn to Dr. Carl Leier regarding the possibility of a cardiac transplant [Ex 5F]. A June, 2000, examination revealed a weight of 189 pounds, standing blood pressure of 126/90, slightly diminished carotid arteries, jugular venous

distention above the clavicles with positive hepatojugular reflux, right ventricular lift moderately hypokinetic with palpable S4 gallop, precordium that was hypokinetic and wide rather than sustained in duration, a loud S4 gallop over the precordium, an occasional ectopic beat, and slightly diminished femoral pulses [Ex 4F/4]. An ECG study revealed normal sinus rhythm, left bundle branch block and an overall abnormal ECG [Ex 4F/6]. Overall, the June, 2000 examination revealed that Ms. Glenn had developed dilated cardiomyopathy with long-standing hypertension as her primary risk-etiological factor. As a result of this condition, she was then left with biventricular enlargement and dysfunction deemed systolic, and likely diastolic as well given her history of hypertension [Ex 4F/4]. Her overall function class at that time was graded to be "II-early III [Id]." At that time, she was taking Zestril, Lanoxin, Norvasc, Normodyne, Lasix, K-Dur, adult aspirin, calcium, and a multivitamin daily [4F/3]. In response to the examination, the Normodyne was converted to carvedilol, Aldactone was added to the treatment regimen, an oxygen consumption study was ordered in order to assess Ms. Glenn's candidacy for cardiac transplantation, and initiation of a regular exercise schedule with daily walking and weights was recommended [Id.].

Following work cessation and resultant stress reduction, Ms. Glenn had made some improvements by July, 2000 [Ex 5F]. However, she continued to experience good days, bad days, and periods where she felt extremely tired, fatigued, and easily run out of steam [Ex 5F/19]. Based on his July 28, 2000, examination of Ms. Glenn, Dr. Patel limited the claimant to lifting no weight, and evaluated Ms. Glenn to be totally disabled for her own occupation,

but was unable to determine the claimant's disability status as to any occupation [Ex 5F/22]. In October, 2000, the claimant's previous implanted ICD device was explanted from her abdominal area due to the battery at end of life and the patient's need for a change to a dual chamber system. The new "InSync" device, a new technique for patients with cardiomyopathy, was implanted by Dr. Charles Love in the pectoral area and involved both biventricular pacing and three leads [Ex 9F/2, 6; 10/10/00 Arrhythmia Device Operative Report, submitted to OHA 02/05/02]. In December, 2000, Ms. Glenn clinically appeared to be doing well, remaining out of significant failure, but still having good days and bad days. She was advised to return in 6 months. In April, 2001, she returned to Dr. Patel earlier than expected with concerns over her LV function. She was experiencing general fatigue, but had been slowly increasing her exercise regimen from walking two to three times per week up to four or five times a week for slightly longer distances [04/06/01 Treatment note, Raj C. Patel, Md, submitted to OHA 10/23/01]. Examination revealed an S4 gallop, and a blood pressure of 148/98. In addition, a 2-D echocardiogram at that time showed an left ventricular ejection fraction of 40 per cent [03/28/01 ECG Report, Capitol City Cardiology, submitted to 01-TA 10/23/01].

In February, 2001, Ms. Glenn had developed a mass in the area of the old pacemaker device. In response, Dr. Love proceeded with debridement of the pacemaker pocket which involved cutting and tying the leads to reduce bulk, and debridement of extensive, necrotic scar tissue [02/28/01 Arrhythmia Device Operative Report, Charles Love, MD, submitted to OHA 02/05/02]. On April 8, 2001, the

claimant presented to the emergency room with complaints of five to ten minutes of heart fluttering and shortness of breath [04/08/01 Emergency Report, submitted to OHA 02/05/02]. The final impression was palpitations, and the claimant was discharged home with instructions to follow up with her regular cardiologist in three days [Id.].

By August, 2001, her blood pressure was 140/90, and cardiac ausculation revealed regular rhythm with an impressive S4 gallop [08/03/01 Treatment note, Dr. Patel, submitted to OHA 08/15/01]. The claimant had reported recently increasing fatigue and exercise intolerance, but denied PND, orthopenea or leg edema [Id.]. In November, the claimant continued to have better exercise tolerance, however she remained fatigued out and short of breath, particularly at times of significant psychological stress [11/02/01 Treatment note, Dr. Patel, submitted to OHA 02/27/02]. However, this treatment note included the following handwritten comment: "Echo in Dec 2001, show moderate LV dysfunction...EF 35 to 40%." The interpretation of the claimant's performance on a December 19, 2001 ECG included the following: "(2) Left ventricular chamber shows mild chamber enlargement with moderate global LV systolic function with an estimated ejection fraction of about 35-40%...; (5) Color flow Doppler study shows mild tricuspid regurgitation. Pulse wave Doppler study shows mild-to-moderate reduction in LV compliance (12/19/01 ECG, Capitol City Cardiology, submitted to OHA 02/27/02]."

On January 18, 2002, the claimant presented to the emergency room with complaints of left arm and left chest pain, that her defibrillator fired, and some

complaints of paresthesias with recent initial of Plavix for questionable TIA [01/18/02 HRT Discharge Summary, submitted to OHA 02/05/02]. The device was the new defibrillator implanted by Dr. Love. Upon examination, Ms. Glenn's blood pressure was 143/98, her pulse was 106, and she appeared uncomfortable secondary to left chest and arm pain [01/18/02 Emergency Report, submitted to OHA 02/05/02]. Interrogation of the device revealed recordings most consistent with sinus tachycardia, and laboratory results revealed mildly low potassium level [01/18/02 HRT Discharge Summary, and Emergency Report, submitted to OHA 02/05/02]. The diagnosis was "arrhythmia, automatic implantable cardiovascular defibrillator fired [Id.]." Ms. Glenn was discharged home with no new prescriptions save for a supplement for her potassium [Id.], and a discussion with regard to her beta blocker therapy occurred [Id].

Admittedly, the residual functional capacity assessment provided for the Administration in November, 2000, and February, 2001, indicated the claimant is capable of light work [Ex 8F]. In part, the reviewing source indicated that the restrictions provided by Dr. Rhee and Dr. Leier are not supported by the medical evidence, specifically that there is no evidence that postural limitations apply. However, both Dr. Rhee and Dr. Patel, who had a longstanding treating relationship with the claimant that the examiner did not have, indicated that such postural activities precipitate symptomatology. Overall, the claimant remained, at all times since her alleged onset date of April 30, 2000, under physical restrictions by Choo Y. Rhee, MD. As the claimant's treating internal medicine physician, he stated in August, 2000, that Ms. Glenn suffered with

chest discomfort characterized by tightness without radiation, precipitated by walking or exertion, relieved by rest, and worsened since January, 2000 [Ex 6F/5]. He noted that the claimant's symptoms of recurrent or persistent fatigue, dyspnea, anginal discomfort, and palpitations occurred upon ordinary physical activity, and that her recovery may have been or may be delayed as a result of idiopathic dilated cardiomyopahty [Id.]. Finally, Dr. Rhee indicated that sitting, standing, walking, bending, lifting, carrying, handling objects, and traveling were restricted; He did not restrict the claimant's hearing, speaking, or mental activities [Id]. In January, 2001, Dr. Rhee assigned the same restrictions, indicated there had been no changed in the claimant's status since November, 2000, but that the claimant's ICD defibrillator has been changed to an InSync ICD [Ex 10F/2-3]. Again, these restrictions were indicated by the claimant's longtime treating physician in response to her delayed recovery, and lapse of hypertension and sudden cardiac death into chronic, severe dilated cardiomyopathy.

In addition, Dr. Patel has never released the claimant back to work since he first recommended to Ms. Glenn that she cease employment in April, 2000. In September, 2000, Dr. Patel responded to a disability inquiry on an Attending Physician Statement of Functional Capacity form provided to him. In it, he opined that Ms. Glenn was totally disabled from her own occupation, but that he could not determine her disability status as to any occupation [Ex 5F/21-22]. On November 20, 2000, Dr. Patel responded to another disability inquiry on a similar Attending Physician Statement form; However on this form, the two questions regarding disability evaluation were flipped. Instead of the

question in the first column relating to disability for the claimant's own occupation, as it had on the September, 2000, Attending Physician form, it referred to any occupation; in response, Dr. Patel indicated total disability for any occupation. Then, the question in the second column inquired about disability status regarding the claimant's own occupation, instead of inquiring into "any occupation" as the September, 2000 form inquired; To this question, Dr. Patel indicated "no." Arguably, if he had not examined the order of the questions, then his response is consistent with his earlier indication that he could not determine disability as to any occupation, and that Ms. Glenn was disabled for her own occupation. This November, 2000, evaluation was conducted at the time when the claimant had not developed any new symptoms and was remaining out of significant failure, but had just submitted to implantation of a new ICD device that not only responded to arrhythmias, but also aided in pumping blood to the heart.

In addition to the previously noted disability evaluations, Dr. Patel indicated as recently as October 15, 2001, the claimant's functioning remained restricted. In addition to findings of impaired myocardial function, Dr. Patel indicated that the severity of Ms. Glenn's symptoms and physical condition were aggravated by emotional stress. While Dr. Patel opined that the claimant would tolerate low stress jobs, he simultaneously opined that Ms. Glenn's symptoms were severe enough to "frequently" interfere with attention and concentration, and that her impairments or treatment would cause three absences from work per month. Again, this opinion was rendered by a longtime treating source who had referred the

claimant for implantation of a new cardiac device, referred the claimant for transplantation assessment, and provided consistent care while the claimant's left ventricular functioning deteriorated.

DISABILITY ARGUMENT

At this point, the claimant, through her representative, asserts that she has not engaged in substantial gainful activity since April 30, 2000. The claimant further asserts that her severe dilated cardiomyopathy treated both conservatively and aggressively since April, 2000, persistent and easily fatigability, and exacerbation of cardiac symptomatology with stress and activities of daily living evidence a severe medically-determined cardiac impairment. As a result of her impairment, the claimant has been unable to tolerate the stress of employment, suffers with good and bad days, and has been unable to predict her pace and persistence at a task or household chore. She has had a period of improvement wherein she was increasing her physical activity; However, her reduced left ventricular functioning persisted to the point of necessitating explanting of 1989 defibrillator device, and implanting a newer "InSync" combination defibrillator/pacemaker device that not only responded to fibrillation events, but also proactively facilitated blood flow through the heart.

While she suffers with a medically-determined severe impairment diagnosed as severe, dilated cardiomyopathy via medically-accepted diagnostic techniques, it is questionable whether her condition meets or equals the severity requirements of any cardiac section of the Appendix I Listings of the Regulations. She did initially suffer with an ejection fraction of less than 30 per cent in March, 2000. It

was reported improved to at least 40 per cent by March, 2001, and at least 35 per cent by December, 2001. Despite failure to meet listing-level requirement of less than 30 per cent, the claimant continues to experience arrhythmia and some left arm and left chest pain. Left ventricular analysis in 1993 revealed left and right projection ventricular wall motion abnormalities, and a New York Heart Association functional class grading of I [Ex 1F/2]. And by June, 2000, she was reclassified as NYHA functional class II-early III [Ex 4F/4], and noted to have right ventricular lift palpable and moderately hypokinetic with palpable S4 gallop [Id].

In the alternative to meeting or equaling a listing, the claimant's severe impairment precludes her successful performance of both her past relevant work and all work at any exertional level. The claimant's past relevant work is light to medium in exertional requirements [Ex 3E/1]. Based on the residual functional capacity assessment completed for the Administration in November, 2000, and January, 2001, the claimant is limited to light work activity; this limitation would not preclude the performance of past relevant work. The claimant maintains, through her representative, that her impairment has resulted exertional and nonexertional limitations that are reasonably related to her diagnosed condition and clinical findings. These limitations preclude her from performing her past relevant work, and limit her residual functional capacity to less then a full range of sedentary work.

Most significantly, the claimant's cardiac symptomatology is often precipitated by minimal activity as indicated by her treating physicians. While the claimant was able to increase her physical

activity, medical testing subsequently revealed diminished ejection fraction and increased fatigue, left arm pain, and left chest pain with arrhythmia. Non-exertionally, Ms. Glenn's constant fatigue with the need to lie down and nap during the day, coupled with the unpredictable bad days renders her an unreliable employee. As indicated by Dr. Patel, bad days would cause this claimant to be absent from her work duties three times per month as a result of cardiac symptoms. Vocationally, this limitation on work activity in even an unskilled work environment, at any exertional range, precludes reliably appearing for scheduled workdays.

Her pace and concentration are additionally impacted by her fatigue. She has remained unable to perform activities of daily living without an unreasonable number and length of interruptions in activity due to the need for rest periods. Overall, this nonexertional limitation significantly prevents the claimant from maintaining a consistent pace or rate of production expected in an unskilled work environment, and precludes her from returning to the level of activity tolerance that would enable her to work on a sustained, consistent basis at any exertional or skill level.

CONCLUSION

The claimant has a history of sudden cardiac death, and has gone on to develop a dilated cardiomyopathy with long-standing systemic hypertension as her primary risk-etiological factor. She suffers with left ventricular dysfunction with dyspnea and pain upon exertion. She has been treated both conservatively and aggressive, yet remains, as evidenced by notes and reports of her treating cardiologists, with a severe medically-determined impairment. Her

impairment has resulted in documented limitations of function including: restriction of postural activities such as sitting, standing, walking, bending, lifting, carrying and handling of objects; interruption of pace and persistence at a task; and the need for frequent rest periods during the day including daytime naps. While her cardiomyopathy and reduced left ejection fraction questionably meet or equal the level severity required of the Appendix I Listings of the Regulations, conservative and aggressive treatments have failed to provide long-term, consistent relief or improvement that would allow the claimant to return to a sustained level of work activity, even at a sedentary exertional level, without exacerbation of her cardiac dysfunction. The claimant is a younger individual with a semi-skilled work history; However, with her severe, chronic cardiac condition that has persisted and resulted in severe limitations, she falls within the purview of Section 201.00(h) of Appendix II of the Regulations. Pursuant to 20 C.F.R.§404.1520(f), Ms. Wanda Glenn, the claimant, is and has been disabled since April 30, 2000, and, therefore, respectfully requested that a decision be made in favor of the claimant's application.

Respectfully submitted,

David B. Kennedy
Representative

By: /s/_____
Valerie C. Barich
Staff Attorney
Kennedy & Associates

Metropolitan Life Insurance Company

MetLife

MetLife DisAbility
PO Box 3017
Utica, NY 13504

10/10/2000

Wanda Glenn
2566 Sonata Drive
Columbus, OH 43209

RE: Long Term Disability
Claim No: 690008108949
Group No: 31003
SS#: [OMITTED]
Group: SEARS ROEBUCK & COMPANY
Phone: 6142362588

Dear Wanda Glenn

Our records indicate that you are not receiving Social Security Disability Insurance Benefits.

Since you have been out of work, you may be eligible for such disability insurance benefits. You should be aware that you have the right to be represented by a qualified person in dealing with the Social Security Administration at any stage of your claim.

If you are approved for Social Security Insurance Benefits, you will realize several advantages:

Social Security Disability Insurance Benefits increase automatically to reflect rises in the cost of living.

As soon as you have been entitled to Social Security Disability Insurance Benefits for 24 consecutive months, you become eligible for Medicare coverage, even though you are under age 65.

Failure to establish a claim for Social Security Disability Insurance Benefits may adversely affect your Social Security Old-Age (Retirement) Benefits.

Since it is to your advantage to receive Social Security Disability Insurance Benefits, we have given your name to **Kennedy & Associates**, a firm that specializes in obtaining Social Security Disability Insurance Benefits for claimants.

Please contact Kennedy & Associates at 1-800-637-0593 in the near future to discuss the feasibility of pursuing a claim for Social Security Insurance Benefits.

MetLife will reduce any overpayment created by your receiving retroactive Social Security Disability Benefit payments by the fee charged by your Representative up to $4,000.00. The Representatives have agreed not to charge other expenses caused by their development of your case. Statistics have shown that people with representation have been more successful in obtaining Social Security Disability Insurance on appeal.

If you currently have an attorney, or other qualified person representing you, simple advise Kennedy & Associates or MetDisability. You may qualify for this reduction also.

This is a voluntary program. Please extend your full cooperation to the representative who helps you as he/she will be doing everything possible to help you

and your family in receiving Social Security Disability Insurance Benefits.

Should Social Security Disability Benefits be awarded while you are represented by Kennedy & Associates and your application results in a retroactive award, a recalculation of the benefits properly payable during the retroactive period will be performed. This adjustment may result in an overpayment and you will be responsible for reimbursing MetLife for monies advanced prior to your Social Security award from the lump sum check sent by Social Security.

Yours truly,

/s/

Ed Peters
Social Security Specialist
Met DisAbility
1-800-300-4296

Cc: Kennedy & Associates
SEARS ROEBUCK & COMPANY

LONG-TERM DISABILITY INSURANCE FOR SALARIED ASSOCIATES

...an extra measure of security

SEARS

SUMMARY PLAN DESCRIPTION

If you are unable to work for a long period of time because of a serious illness or injury, your paychecks would stop—but you'd still have regular living expenses. Sears Group Long-Term Disability (LTD) Insurance Plan makes sure that you'll have a continuing source of income to help meet those expenses throughout a disability.

This booklet is a Summary Plan Description which describes the provisions of the Plan that apply to salaried associates. Should your employment status change to that of hourly, contact your Human Resources representative or unit manager to obtain a copy of the booklet which describes the provisions that apply to hourly associates.

The provisions outlined in this booklet apply to participants who become Totally Disabled on or after January 1, 1995.

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A SUMMARY OF HOW LTD WORKS

If you are unable to work due to a serious illness or injury that lasts longer than 140 out of 180 consecutive days (the "Waiting Period"), you may be entitled to benefits from the LTD Plan.

In order to qualify for LTD benefits, the following rules apply:

- To qualify for LTD benefits during the Waiting Period and for the next 24 months, you must be unable to perform the material duties of your own job.
- To continue receiving LTD benefits beyond 24 months, you must be disabled to the point that you are unable to perform the duties of your own job and all other jobs for which you are Reasonably qualified.

Subject to certain limitations, you will be eligible to receive LTD benefits as long as you remain disabled under these definitions, but not beyond the date of your death or age 65, whichever comes first. However, if your disability starts after age 62, benefits are paid according to a schedule and may extend beyond age 65.

These provisions are explained in more detail in the following pages of this booklet.

PARTICIPATING COMPANIES

The Plan covers eligible associates of Sears, Roebuck and Co. and the following entities:

- Sears Investment Management Co.
- Sears Roebuck Acceptance Corp.
- Sears Roebuck de Puerto Rico, Inc.
- Sears Buying Services. Inc.
- Sears Logistics Services, Inc.
- Circle of Beauty Inc.
- Sears Shop-at-Home Services, Inc.
- Sears National Bank
- Wilkes-Barre Logistics Services, Inc.
- Delano Logistics Services, Inc.
- Sears Development Co. (effective 4/1/96)

ELIGIBILITY AND ENROLLMENT

You are eligible to enroll in the LTD Plan if, according to Sears established personnel practices, you are a salaried associate of a participating company.

Participation in the Plan is voluntary. To enroll for LTD, you must fill out and sign an enrollment form and return it to your Human Resources representative or unit manager. This form will authorize Sears to deduct your contributions for LTD coverage from your paycheck.

Normal Enrollment

You have one month from the date you first become eligible to enroll in the Plan. If you are absent on the day you become eligible, you have one month from the day you return to Active Work to enroll. If you

enroll during this time, you will not be required to provide evidence of good health.

Late Enrollment

If you enroll more than one month after the date you first become eligible, you must provide evidence of good health that is satisfactory to MetLife before your coverage can begin. You will also need to provide evidence of good health if your coverage ends because you cancel it or fail to pay your contributions and you later want to re-enroll. Forms for this purpose may be obtained from your Human Resources representative or unit manager. If additional medical information or a medical examination is necessary, you will be required to pay the cost. Your coverage will not begin until your enrollment has been approved by MetLife.

WHEN COVERAGE BEGINS

Coverage in the LTD Plan always begins on the first day of a month.

Normal Enrollment

If you enroll in the Plan when you first become eligible, your coverage will begin is follows:

- If you return your completed enrollment form on the first day of a month, your coverage will begin on that day.
- If you return your completed enrollment form on a day other than the first day of a month, your coverage will begin on the first day of the following month.

For example, if you are hired as a salaried associate on July 16 and you complete and return your

enrollment form on or before August 1, your coverage will begin on August 1. However, if you were to complete and return your enrollment form on August 10, your coverage would not begin until September 1.

Late Enrollment

If you do not enroll during your normal enrollment period, or if you cancel your LTD coverage and later want to re-enroll, your coverage will begin:

- on the date that MetLife approves your application for coverage, if your application is approved on the first day of a month; or
- on the first day of the month following the date that MetLife approves your application for coverage, if your application is approved on a day other than the first day of a month.

Actively at Work

However, if you are not at work due to illness or injury on the day your coverage is supposed to begin, your coverage will not begin until:

- the day you return to Active Work, if you return on the first day of a month; or
- the first day of the month following your return to Active work, if you return on a day other than the first day of a month.

WHEN COVERAGE TERMINATES

Your coverage ends on the earliest of the following dates:

- the end of the month in which your employment terminates;
- the end of the month in which you are placed on an approved Military Leave of Absence if your leave becomes effective after the first of a month, or
- the end of the month prior to being placed on an approved Military Leave of Absence if your leave becomes effective on the first of a month;
- the end of the month in which you cancel your membership in the Plan;
- the end of the month for which you last made a required contribution;
- the end of the month in which you no longer meet eligibility requirements;
- the date of your death; or
- the date the Plan terminates.

If your coverage ceases due to Military Leave of Absence, you will be offered the opportunity to re-enroll upon your return to Active Work.

Suspension of Coverage

You may not continue your LTD coverage while you are on a Unit Closing, Layoff, or Personal Leave of Absence. However, if your have of absence becomes effective after the first of a month, you must make

the required contributions for that month, and your coverage will continue until the end of the month.

Your coverage will begin again on the first day of the month which coincides with or immediately follows your return to Active Work. You will not need to provide evidence of good health.

PAYMENT OF CONTRIBUTIONS

You pay the full cost of your membership in the Plan. You do so by making contributions through payroll deductions. Deductions for salaried associates are made at the end of each month for-coverage that month.

LTD coverage is provided on a monthly basis. Therefore, if you are covered for any portion of a month, you are covered for the entire month and a full month's contributions are required.

Q
How much will I pay for LTD Coverage?

In the event you have no earned income from which to deduct your contributions when they are due, Sears will advance up to one month's contributions for you. However, you must reimburse Sears for the advanced contributions before the next contribution is due. If reimbursement is not made on a timely basis, coverage will terminate on the last day of the month for which your last

A
LTD contribution rates are subject to change. Contact your Human Resources representative for current rates.

contribution applied.

You may continue your membership during an authorized illness, Workers' Compensation, or Family Care Leave of Absence. In such cases, you must continue paying required contributions during your absence to maintain your coverage.

Contribution Amount

Your contribution amount is based on your Eligible Annual Earnings, up to a maximum of $150,000. When you first enroll, Sears will estimate your Eligible Annual Earnings. Sears may also estimate your Eligible Annual Earnings in other situations.

Each January, the amount of your required contribution will be recalculated, based on your Eligible Annual Earnings in the prior Payroll Year. The new contribution amount will be effective February 1. (See page 12 for exceptions to this rule.)

Eligible Annual Earnings are calculated in accordance with Sears established personnel practices and include most types of taxable income, such as:

- regular pay; and
- commissions and incentives.

Eligible Annual Earnings do not include Workers' Compensation statutory payments, State Disability

payments, LTD benefits, and earnings such as contest awards, suggestion awards, moving allowances, etc.

LTD Contributions During Total Disability

If you become Totally Disabled, you must continue to pay your LTD contributions during the Waiting Period. Once you qualify for LTD benefits, you will not have to pay any further LTD contributions during the period in which you receive LTD benefits, beginning the first of the month which coincides with or immediately follows the date that benefits become payable.

DESCRIPTION OF BENEFITS

If:

- you become Totally Disabled as a result of an illness or injury;
- you are covered by the Plan at the time you become Totally Disabled;
- you remain Totally Disabled throughout the Waiting Period;
- you continue to be Totally Disabled after completing the Waiting Period; and

- you are under the regular care and treatment of a Physician;

you will be entitled to LTD benefits. Because you pay the full cost of your membership in the Plan, LTD benefits are free from federal income tax under current tax laws.

Benefits begin after you complete the waiting Period, and continue as long as you remain Totally Disabled until the end of your Maximum Benefit Period (see page 11).

Q

When do LTD benefits being?

A

LTD benefits begin after you have been Totally Disabled for 140 days (out of 180 consecutive days).

These provisions are discussed in greater detail in the following pages.

Meaning of Total Disability

To receive benefits from the Plan, you must be Totally Disabled.

As used in the Plan, the term "Total Disability" has two definitions:

1. During the Waiting Period and for the next 24 consecutive month's, "Total Disability" means that because of Illness or Injury, you cannot perform the material duties of your own

job.

2. After that time period, you will no longer be considered Totally Disabled unless you are totally incapable of performing the material duties of any gainful occupation for which you are reasonably qualified based on your training, education, and experience.

If you are engaged in any occupation for wage or profit during the Waiting Period, you are not Totally Disabled. After the Waiting Period, if you are engaged in any occupation for wage or profit other than Rehabilitative Employment approved in advance by MetLife, you are not Totally Disabled.

Waiting Period

If you are Totally Disabled due to the same or related Illness or Injury for 140 days within any 180-consecutive-day period, you will have completed the Waiting Period.

Recurring Disabilities

If you complete the Waiting Period, begin to receive LTD benefits, return to Active Work, and resume your LTD contributions, you may be required to complete another Waiting Period if you become Totally Disabled again.

This second period or Total Disability will be treated as a continuing disability if it;

- begins within six months following your return to Active Work; and
- is due to the same or related causes.

Benefits will resume immediately without a new Waiting Period, and the Maximum Benefit Period will apply to the total benefits in all periods.

Otherwise, the second period of Total Disability will be treated as a new disability and you will need to complete a new Waiting Period before LTD benefits can begin again.

Medical Evidence

To qualify for benefits under the Plan, Total Disability must be supported by current medical documentation. You must be under the regular care of a qualified Physician under a course of treatment appropriate for the disability.

You may be asked to undergo a medical examination by a Physician designated by MetLife. For example, if your Physician cannot substantiate a finding of Total Disability with objective evidence, an independent evaluation may be required. When MetLife requires you to undergo an examination by their appointed Physician, this examination will be at MetLife's expense.

If you cannot or will not provide conclusive medical evidence of Total Disability, LTD benefits will be denied or discontinued.

Continuation of LTD benefit payments will require ongoing certification of disability based on updated medical documentation. MetLife will determine how often you will need to provide updated medical documentation.

When Benefits Are Not Payable

LTD benefits will not be paid if:

- you are not under the regular care of a Physician;
- you do not submit satisfactory proof of your Total Disability to MetLife;
- you are engaged in any occupation for wage or profit, except for Rehabilitative Employment;
- your Total Disability begins after your coverage has been terminated or suspended; or
- your Total Disability is the result of a Pre-Existing Condition.

Additionally, LTD benefits are not paid for disabilities resulting from:

- intentionally self-inflicted injuries (while sane or insane);
- insurrection, riot, or war;
- your services in the armed forces of any country; or
- your participation in a felony.

Pre-Existing Conditions

A "Pre-Existing Condition" is an Injury or Illness that occurred or began before you became a Plan member. You will nor be entitled to LTD benefits if, for that condition, you took prescribed drugs or medicine or received medical treatment or consultation, medical care or services, or diagnostic tests in the six months before you became a Plan member.

However, you will be entitled to LTD benefits for a Pre-Existing Condition if your Total Disability due to that condition begins 12 or more months after you become covered by the Plan.

Mental Nervous Disorders

Payment of LTD benefits is limited to a maximum of 12 consecutive months if the disability results from a mental and nervous disorder.

A disability is due to a mental and nervous disorder if:

- it is due to mental or emotional disease or disorder of any kind; and
- you would not be Totally Disabled in the absence of the mental and nervous disorder.

However, if you are confined at the end of that 12-month period in a hospital or other similar institution which is licensed to provide care and treatment for such disorders, then LTD benefits will continue during the time that you continue to be confined (but not beyond the Maximum Benefit Period), and will stop immediately upon your discharge. You will not be eligible for any further benefits for that disability, even if it recurs.

When Benefits End

As long as you remain Totally Disabled, continue under the regular care of a Physician, continue to provide evidence of that disability to MetLife, and are not disabled from a mental and nervous disorder, LTD benefits will continue until the end of the Maximum Benefit Period that applies – to you or until your death, if sooner.

The "Maximum Benefit Period" that applies to you is the period shown in the right-hand column of this chart opposite your age at the time benefits under the Plan begin for your Total Disability.

AGE WHEN BENEFITS BEGIN	MAXIMUM BENEFIT PERIOD
Up to and including age 61	To age 65
62 or 63	To age 65 or for 31 months, whichever is later
64, 65, or 66	31 months
67	31 months, but not beyond age 70
68	To age 70
69 or older	12 months

AMOUNT OF BENEFITS

The amount of the benefit you will receive during a period of Total Disability is based on your Eligible Annual Earnings.

Your Eligible Annual Earnings are calculated during the month of January and are based on your earnings in the prior Payroll Year.

Increases in Earnings

If, at the time of the calculation, your Eligible Annual Earnings have increased to qualify you for a higher amount of LTD coverage, the increase will be effective the following February 1.

Decreases in Earnings

If, at the time of the calculation, your Eligible Annual Earnings have decreased to qualify you for a lesser amount of LTD coverage, the decrease will be effective the following February 1. However, for salaried associates, a decrease will only take effect if your Eligible Annual Earnings have qualified you for a lesser amount of LTD coverage for two years in a row.

Any Payroll Year in which you were on an approved leave of absence for two months or longer will be ignored for purposes of decreases.

Leave of Absence at Time of Recalculation

If you are on an approved leave of absence on the day the recalculation is made, a recalculation will not be done for you. Neither your contribution amount nor the amount of your LTD coverage will be changed.

Monthly LTD Covered Earnings

Your Monthly LTD Covered Earnings are equal to your Eligible Annual Earnings in effect on the day after completion of the Waiting Period, rounded to the next higher thousand, and divided by 12.

For instance, if your Eligible Annual Earnings fall between $47,000.01 and $48,000.01, your Monthly LTD Covered Earnings are $4,000 ($48,000 divided by 12).

Amount of Monthly Benefit While Totally Disabled.

The amount of the monthly LTD benefit you win receive while you are Totally Disabled is equal

to 60% of the First $12,500 of your Monthly LTD Covered Earnings less (a) any Other Income Benefits to which you are entitled and (b) 50% of your Rehabilitation Earnings, if any.

If necessary, your monthly LTD benefit will be reduced so that the total amount you receive from LTD, Rehabilitation, and Other Income Benefits does not exceed your Monthly LTD Covered Earnings.

The maximum amount of monthly LTD benefit you can receive from the Plan is $7,500.

The minimum amount of monthly LTD benefit you can receive from the Plan is $100, unless MetLife has made an overpayment of benefits to you (see page 15).

Q

How much will my LTD benefit be?

A

LTD will pay you up to 60% of your pre-disability income when combined with other income such as Social Security and Workers' Compensation.

Other Income Benefits

Other Income Benefits you are eligible to receive affect the amount that the Plan pays you in monthly LTD benefits.

Other Income Benefits include:

- Social Security benefits payable to you, your spouse, your child, or your children because of your disability or on account of your age;
- any benefits you are eligible to receive under Workers' Compensation or similar laws, whether paid in a lump sum or as periodic payments. This includes (but is not limited to) permanent disability awards, temporary disability awards, and compromise settlements;
- any disability income benefits you are eligible to receive under any compulsory municipal, state, or federal government disability plans or laws (excluding any V.A. benefits); and
- any disability income benefits you are eligible to receive under any compulsory benefit act or law under which any employer makes contributions or payroll deductions, such as the Puerto Rico Non-Occupational Disability Benefits Act #139 and Chauffeurs Social Security Act #426.

All amounts available to you as Other Income Benefits will be used to calculate your monthly LTD benefit whether or not you actually apply for and receive those amounts.

For example, if you are covered under the federal Social Security Act for disability or old age benefits for yourself and your dependents or if your Total Disability is work-related and you are eligible to apply for Workers' Compensation benefits, the Plan will assume you are receiving these benefits. The Plan estimates the benefits you and your dependents are eligible to receive and uses this amount in the calculation of your monthly LTD benefit. Therefore,

it is to your advantage to apply promptly for any other benefits to which you may be entitled.

Social Security Benefits

You can request assistance in applying for Social Security benefits by contacting MetLife's Group Long-Term Disability Claim Department.

Often, the approval or denial of a claim for Social Security benefits takes quite a while. Therefore, MetLife has the right to estimate Social Security benefits during the first 24 months of your disability benefit period. Included in the estimate will be Social Security benefits for you, your spouse, and your children.

However, if not later than 90 days following the date of the first LTD monthly payment, you provide MetLife with written confirmation from the Social Security Administration that you have applied for Social Security benefits, then your monthly LTD benefit will not be reduced by estimated Social Security benefits.

MetLife will require you to sign an agreement:

- confirming that you will repay MetLife any overpayments caused by receipt of Social Security benefits, including retroactive payments; and
- authorizing MetLife to obtain information on awards directly from the Social Security Administration.

When MetLife receives notification of your Social Security award or denial, it may cause a change in the amount of your monthly LTD benefit. For instance, if MetLife had been estimating your Social Security benefits at $500 per month and you are

awarded only $400 per month, MetLife will recalculate your LTD monthly benefit and pay you amounts owed to you for past months in a lump sum. On the other hand if you are awarded benefits that are greater than those that MetLife had been estimating, or if MetLife did not reduce your LTD benefit by estimated Social Security benefits, then you will be required to repay MetLife for the resulting overpayment.

Once you begin receiving LTD benefits from the Plan, your LTD benefit will not be reduced to reflect changes in your Social Security disability or retirement benefits due to cost-of-living increases. However, your monthly benefit will be adjusted to reflect changes in your Social Security payments due to changes in your marital or family status.

Workers' Compensation Benefits

If you receive benefits in the form of a lump sum under a Workers' Compensation or similar law, the monthly equivalent of these benefits will be determined as follows:

- If the lump-sum payment specifies the number of months for which the award or settlement is applicable, then the monthly equivalent is the dollar amount of the lump-sum payment divided by the number of months specified.
- If the lump-sum payment does not specify the number of months for which the award or settlement is applicable, then the monthly equivalent is the maximum Workers' Compensation benefit available under state law for the type of disability you have.

The amount of the monthly equivalent will be used in the calculation of your monthly LTD benefit until the total amount of the award or settlement is exhausted.

Overpayments

If it is determined that LTD benefits were overpaid to you, you will be required to repay Metlife for the overpayment. MetLife has the right to recover overpayments by applying them against all or part of future monthly LTD benefits until the overpaid amount has been recovered.

REHABILITATIVE EMPLOYMENT

Q
I've been receiving LTD benefits but would like to try to work. Will my LTD stop?

A
MetLife may approve your return to employment as rehabilitative. In that case, you could continue to receive a portion of your LTD

The Plan provides for a program designed to help you return to active, permanent work. However, such a program must be approved by MetLife, Rehabilitation programs may include training, physical therapy, or part-time work in your old job or a new job.

You will be considered to be engaged in a rehabilitative program if the following conditions are met:

- you have completed the Waiting Period;
- you are Totally Disabled; and
- after completion of the Waiting Period you begin a program of rehabilitative

benefit. Contact your MetLife claim adjuster to discuss the possibilities.

employment for wage or profit, approved in writing in advance by MetLife.

You may receive LTD benefits for up to 24 months while you are Totally Disabled and engaged in Rehabilitative Employment as part of a rehabilitation program. "Rehabilitative Employment" is defined as employment for wage or profit that is intended to retain you for productive employment. MetLife determines what type of employment qualifies for Rehabilitative Employment.

While you are in a period of Rehabilitative Employment, your monthly LTD benefit is offset by 50% of your Rehabilitation Earnings.

AMOUNT OF BENEFITS — EXAMPLES

The following examples show how the Plan works.

EXAMPLE 1 — NO OTHER INCOME BENEFITS OR REHABILITATION EARNINGS
Assume your Eligible Annual Earnings are $48,000. Therefore, your Monthly LTD Covered Earnings are $4,000 ($48,000 divided by 12). Your monthly LTD benefit is calculated as follows: **$4,000 x 60% = $2,400 from the Plan**

EXAMPLE 2 - INDIVIDUAL SOCIAL SECURITY BENEFITS

As in Example 1, assume your Eligible Annual Earnings are $48,000, and your Monthly LTD Covered Earnings are $4,000. Assume you apply for and receive a Social Security disability benefit of $800 per month. Your monthly LTD benefit is calculated as follows:

$4,000 x 60% = $2,400

minus

your monthly Social Security benefit ($800)

equals

$1,600 from the Plan

EXAMPLE 3 – INDIVIDUAL WITH INDEPENDENT CHILDREN

As in Example 2, assume your Monthly LTD Covered Earnings are $4,000. However, because you have dependent children, you apply for and receive a family Social Security disability benefit in addition to your individual Social Security disability benefit, totaling $1,200 per month. Your monthly LTD benefit is calculated as follow:

$4,000 x 60% = $2,400

minus

your monthly individual and family Social Security disability benefit ($1,200)

equals

$1,200 from the Plan

EXAMPLE 4 - INDIVIDUAL AFTER AGE 65

Assume you become Totally Disabled at age 66, your Monthly LTD Covered Earnings are $4,000, and you apply for and receive a Social Security retirement benefit of $1,000 per month, Your monthly LTD benefit is calculated as follows:

$4,000 x 60% = $2,400

minus

your monthly Social Security retirement benefit ($1,000)

equals

$1,400 from the Plan

EXAMPLE 5 - REHABILITATION EARNINGS

Assume your Monthly LTD Covered Earnings are $4,000 and, during Total Disability after Plan benefits begin, you begin earning $2,500 a month from Rehabilitative Employment. Assume you have no Other Income Benefits. Your monthly LTD benefit is calculated as follows:

$4,000 x 60% = $2,400

minus

50% of your earnings from Rehabilitative Employment ($2,500 x 50% = $1,250)

equals

$1,150 from the Plan

Therefore, your total monthly payments from both the Plan and Rehabilitative Employment would be $3,650 ($1,150 Plan benefits and $2,500 Rehabilitation Earnings).

APPLYING FOR BENEFITS

Claim Filing Procedures

If you suffer an Illness or Injury and it appears that you will be disabled for more than 20 weeks, you should ask your Human Resources representative to obtain an LTD Claim Kit for you. We encourage you to begin the claim filing process after you have been out of work for approximately eight weeks. A claim must be filed within 20 days after completing the Waiting Period, or as soon as is reasonably possible.

The LTD Claim Kit contains several forms. When you receive the Kit, complete and sign the front side

of the claim form tided "Claimant's Statement of LTD Claim." You should then request your Physician to complete the remainder of that form. A return envelope will be provided for your Physician to return the form to Sears.

You will also need to complete the Training, Education, and Experience Statement; the Consent for Release of Information; and the Reimbursement Agreement. You should return these to Sears in the return envelope which will be included in the Claim Kit.

Upon receipt of the information from you, your Physician, and Sears, MetLife will evaluate the information and make a decision regarding your claim. It may be necessary for MetLife to request additional information or schedule an independent medical examination in order to reach a final decision regarding your claim.

Payment of Benefits

Upon approval of your claim, you will be paid all benefits due you up until that time (from the day following completion of the Waiting Period through the end of the month before the date of approval) in one lump sum. Subsequent payments will be made on a monthly basis. All payments will come directly to you from MetLife. For each day of a partial month, 1/30 of a full month's benefit is payable.

Benefits will be paid to you, or if you die, any applicable benefits remaining will be paid to your estate.

If Your Claim Is Denied

If your claim is denied, you will be notified in writing by MetLife. This notification will tell you about your

rights to have a review of the decision and will tell you what you must do to request the review. You will then have 60 days in which to appeal your claim in writing to:

MetLife
Group Long-Term Disability Claims
P.O. Box 3043
Utica, NY 13504

MetLife will reevaluate all the information, and you will be informed of the decision in a timely manner.

DEFINITIONS

"Actively at Work" or **"Active Work"** means you are performing for Sears the duties of your employment at the place and in the manner in which the duties of your employment are usually and customarily performed.

"Eligible Annual Earnings" means annual benefit earnings as determined by Sears established personnel practices.

"Illness" means pregnancy or disease which causes a deterioration in the state of health of the afflicted person.

"Injury" means accidental bodily injury.

"Payroll Year" means a 12-month period determined according to Sears established personnel practices.

"Physician" means a person who is licensed or otherwise legally authorized to administer medical care or treatment so long as the person is acting within the scope of his/her license or authorization. "Physician" also means an accredited Christian

Science practitioner listed in the current issue of the *Christian Science Journal*.

"Rehabilitation Earnings" means the amount of wage or profit you receive because you are engaged in Rehabilitative Employment.

"Rehabilitative Employment" means a type of employment that MetLife accepts as being employment which is designed to rehabilitate you while you are Totally Disabled and for which you receive wage or profit.

"Totally Disabled" or **"Total Disability"** is defined on page 8.

"Waiting Period" is defined on page 9.

OTHER PROVISIONS

Assignment

You may not assign your LTD benefits to any other person or entity.

Misstatements and Errors

If your age is misstated, the duration of your benefits will be adjusted accordingly.

Clerical errors will not void coverage which should be in force, nor will they continue coverage which should have ended. When an error is found, a fair adjustment in the contribution or amount of benefit will be made.

No statement made by you can be used to contest your coverage after your coverage has been in effect for two years. No statement of yours can be used to contest your coverage unless it is in writing and signed by you, and a copy was given to you.

Overpayments

If overpayments are made by MetLife, MetLife has the right to recover the amount of overpayment from you, your estate, or the person to whom payments were made.

Facility of Payment

If Plan benefits become payable, and you are a minor or, in MetLife's opinion, legally incapacitated, MetLife may make payment of $2,000 or less to an individual or institution it believes has assumed custody or principal support of you. Payments made in good faith under this provision will fully discharge MetLife to the extent of the payment.

Legal Actions

You must wait at least 60 days after filing an LTD claim before you may bring a lawsuit involving LTD benefits. Lawsuits may not be brought more than three years after an LTD claim was or should have been filed.

Plan Discontinuance

You will he given written notice by Sears at least 15 days before the date of any discontinuance of the LTD Plan.

PLAN DOCUMENTS

This booklet is the Summary Plan Description (SPD) for the Plan required by the Employee Retirement Income Security Act of 1974 (ERISA).

The detailed terms and conditions of the Plan are contained in the insurance certificate which is part of the group insurance policy issued by MetLife to Sears, Roebuck and Co. The policy is the controlling

document in all respects. If there are any discrepancies between this booklet and the policy provisions, the policy provisions will govern.

You may obtain a copy of the Insurance Certificate by sending a written request to:

MetLife
Group Long-Term Disability Claims
P.O. Box 3045
Utica, NY 13504

The complete policy will be available for your examination in the Sears Corporate Benefits Department. As an alternative, upon written request to the Plan Administrator, it will be mailed to the Human Resource Department of your unit. Your unit will notify you when the policy is available. You will then have 10 days within which to complete your examination of it.

As another alternative, upon written request to the Plan Administrator, a copy of the Policy will be provided to you at a cost no greater than $.25 per page.

ADDITIONAL INFORMATION ABOUT THE PLAN

Plan Name and Identification

The official name of the Plan is the "Sears Group Long-Term Disability Insurance Plan."

The Plan is identified by the following numbers in accordance with the rules of the Internal Revenue Service:

- Employer Identification Number-36-1750680
- Plan Number-506

Type of Plan

The Plan is a group insurance plan governed by the Company's group insurance policy with MetLife, One Madison Avenue, New York, NY 10010.

Plan Year

The Plan year is the calendar year, January 1 through December 31.

Plan Financing

The Company intends that the Plan be funded solely by associate contributions. However, at the discretion of the Company, the Plan may be funded by a combination of associate and Company contributions. Sears pays monthly premiums to MetLife. Benefits are payable from Metlife.

Plan Administration

Sears, Roebuck and Co. administers the Plan through a Plan Administrator. The Plan Administrator is the Manager, Personnel Policy and Technical Support.

The Plan Administrator has the authority to determine questions arising under the provisions of the Plan, including the power to determine the rights and eligibility of associates, participants, or any other persons, and to remedy ambiguities, inconsistencies, or omissions.

MetLife has the responsibility of Claim Fiduciary for the provision of full and fair review of claim denials pursuant to Section 503 of ERISA.

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have the discretionary authority to interpret the terms of the Plan and to

determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

If you have any questions about the Plan or your benefits, you should contact your local Human Resources representative or write the Plan Administrator at the following address:

Manager, Personnel Policy and Technical Support
Sears, Roebuck and Co.
Department 707BEN
3333 Beverly Road, E2-103B
Hoffman Estates, IL 60179

The person designated above is also the designated agent for service of legal process.

Plan Amendment and Termination

Although Sears intends to continue the Plan at the direction of the Company, the Vice-President of Benefits has the right to modify, amend, suspend, or terminate the Plan at any time.

ERISA RIGHTS

As a participant in the Group Long-Term Disability Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- examine, without charge, at the Plan Administrator's office end at other specified locations, all Plan documents, including

insurance contracts, and copies of all documents filed by the Plan with the United States Department of Labor, such as detailed annual reports and Plan descriptions;

- obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies; and
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

* * *

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IN THE

Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF FOR PETITIONERS

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QUESTIONS PRESENTED

I. Whether the fact that the claim administrator of an ERISA plan also funds the plan benefits, without more, constitutes a "conflict of interest" that must be weighed in a judicial review of the administrator's benefit determination.

II. If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all the parties to the proceeding below.

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

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BRIEF FOR PETITIONERS

OPINIONS BELOW

The court of appeals' opinion is reported at 461 F.3d 660. Pet. App. 1a. The opinion of the United States District Court for the Southern District of Ohio is unpublished but is electronically reported at 2005 WL 1364625. *Id.* at 27a.

JURISDICTION

The judgment of the court of appeals was entered on September 1, 2006. On November 22, 2006, Justice Stevens extended the time within which to file a petition for a writ of certiorari to January 2, 2007 (a Court holiday). No. 06A524. The petition for a writ of certiorari was filed on January 3, 2007, and granted on January 18, 2008. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant provisions of the Employee Retirement Income Security Act of 1974 (ERISA) and the Department of Labor's implementing regulations are set forth in the appendix to this brief.

STATEMENT

1. After a decade of congressional study, Congress enacted ERISA "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). ERISA did not "require[ ] employers to establish employee benefits plans" or "mandate[ ] what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). It instead "encourag[ed] the formation" of such plans by establishing a legal framework

that facilitates cost-effective plan administration (*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)) and that "minimize[s] the administrative and financial burden of complying with conflicting [state-law] directives." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (internal quotation marks omitted). ERISA was thus carefully designed "to strike an appropriate balance" between "the need of the workers for a level of protection which will adequately protect their rights" and the "interests of employers . . . in maintaining flexibility in the design and operation of their pension programs." S. Rep. No. 93-127, at 13 (1973).

The procedural framework that ERISA established for challenging plans' benefit determinations reflects Congress's "careful balancing" between the dual statutory objectives of protecting plan participants and promoting plan formation. *Pilot Life*, 481 U.S. at 54. For example, ERISA authorizes a plan participant to bring a civil action "to recover benefits due to him under the terms of the plan" (29 U.S.C. § 1132(a)(1)(B)), but restricts the availability of individualized monetary relief. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985). ERISA also expressly preempts all state-law claims that "relate to any employee benefit plan" (29 U.S.C. § 1144(a))—thereby restricting plan participants to the remedies afforded by ERISA itself—while expressly saving state laws that regulate insurance from preemption. *Id.* § 1144(b)(2)(A); *see also Davila*, 542 U.S. at 209 ("the ERISA civil enforcement remedy" is "exclusive"). Together, these provisions create a uniform federal regulatory framework that facilitates the fair and efficient administration of employee benefit plans and that preserves state regulation of the in-

surance business. *Egelhoff v. Egelhoff*, 532 U.S. 141, 148, 149 n.3 (2001).

2. Petitioner Metropolitan Life Insurance Company (MetLife) administers benefit claims for petitioner Sears Long Term Disability Plan (Plan), an employee welfare benefit plan sponsored by Sears, Roebuck and Company (Sears). J.A. 181a. MetLife "has the responsibility of Claim Fiduciary for the provision of full and fair review of claim denials." *Id.* MetLife is also the issuer of the insurance policy that funds the Plan's benefits. *Id.* The terms of the Plan expressly afford MetLife, as Claim Fiduciary, "discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan." *Id.*

Under the Plan, participants are entitled to receive sixty percent of their salary if they become "totally disabled." J.A. 165a-66a. During the first 24 months of disability payments (and during the initial 140-day elimination period that must precede the payment of any benefits), a participant is totally disabled if she "cannot perform the material duties of [her] own job." *Id.* at 159a-60a. After 24 months, the Plan provides that a "Total Disability" exists only if the participant is "totally incapable of performing the material duties of *any gainful occupation* for which [she is] reasonably qualified." *Id.* at 160a (emphasis added). If a participant who is receiving benefits ceases to be totally disabled under the operative Plan definition, the payment of disability benefits is terminated. *Id.* at 161a.

3. Respondent Wanda Glenn worked as a Sears sales manager between 1994 and 2000. J.A. 100a. She worked forty to fifty hours per week, and directly

supervised twenty to thirty sales associates. *Id.* at 115a, 117a. Her responsibilities involved some climbing, reaching, stooping, and lifting, and required standing 20-60% of the workday and walking 61-100% of the workday. *Id.* at 116a.

On March 3, 2000, Glenn visited her treating physician, Rajendra Patel, complaining of chest tightness. J.A. 92a. Dr. Patel diagnosed her as suffering from dilated cardiomyopathy, a condition associated with an enlarged heart and a thinned and weakened heart muscle. *Id.* at 91a. Tests indicated that Glenn's left ventricle ejection fraction—which measures the efficiency with which the heart delivers blood to the body—was only 22%. *Id.* at 89a. An ejection fraction below 35% is considered poor.[1]

In light of this diagnosis and Glenn's reports of fatigue, Dr. Patel advised Glenn to stop working and to begin claiming disability benefits. J.A. 82a-83a. He explained that, "[c]onsidering her low ejection fraction, I feel that she may not be able to continue to work in any kind of environment that would cause significant physical or psychological stress and demands." *Id.* at 82a.

Glenn submitted her long-term disability claim to Sears on June 20, 2000. C.A. App. 288. The claim was supported by an "Attending Physician Statement" from Dr. Patel, which stated that Glenn was disabled from performing her job at Sears. J.A. 109a. Dr. Patel also initially checked a box indicating that Glenn was not totally disabled "For Any Occupation." *Id.* It appears that Dr. Patel then crossed this out, and checked that he "Cannot Determine"

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[1] *See* Medtronic, Inc., Ejection Fraction and Its Importance, *at* http://www.hearthelp.com/sca/ejection-fraction.html.

whether Glenn was totally disabled for any occupation. *Id.*

Sears transmitted Glenn's claim to MetLife for a determination. MetLife concluded that Glenn could not "perform the material duties of [her] own job" (J.A. 159a-60a) and that she was therefore totally disabled within the meaning of the Plan. Glenn began receiving long-term disability benefits in September 2000 following completion of the 140-day elimination period.

After submitting her claim, Glenn began to respond well to new medication prescribed by Dr. Patel. Indeed, by July 2000, Glenn told Dr. Patel that she "felt much better." J.A. 84a. Dr. Patel reported at that time that she was doing "clinically well," and another cardiologist to whom she was referred also stated that she showed "good functional capacity and tolerance." *Id.* at 84a-85a.

Glenn's health continued to improve after her implantable cardiac defibrillator (ICD)—which she had received when she first experienced heart problems in the late 1980s—was replaced in October 2000 with a device that included both a defibrillator and a pacemaker with "biventricular pacing," a newly developed technique for treating cardiomyopathy. J.A. 71a, 75a. Unlike an ICD device, which is only designed to prevent death should cardiac arrest occur, a device with biventricular pacing actually helps "enhance cardiac function," causing a reduction in heart enlargement and increasing the ejection fraction and cardiac output.[2] Indeed, by December

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[2] *See* Cheuk-Man Yu, *New Insight into Left Ventricular Reverse Remodeling After Biventricular Pacing Therapy for Heart Failure*, 9 Congestive Heart Failure 279, 279-83 (2003); Cleve-

2000, Dr. Patel reported that Glenn was doing "clinically well," and by April 2001, her ejection fraction had improved to 40-50%. J.A. 72a, 74a. Dr. Patel noted at that time that Glenn was walking four or more laps around the mall four or five times a week, as compared to two laps two or three times per week previously. In November 2001, Dr. Patel reported that Glenn continued to have "better exercise tolerance than before" and that she was "clinically stable." *Id.* at 62a-63a.

4. Under the Plan, benefit payments are reduced if a participant is receiving or is eligible for (but not actually receiving) other benefits, such as social security disability benefits (SSDB). J.A. 166a-68a. The Plan also provides that estimated SSDB will not be deducted if the participant has applied for such benefits and agrees to repay the Plan for all overpayments resulting from an SSDB award. *Id.* at 168a.

When MetLife determined that Glenn might be eligible for SSDB, it did not reduce her benefit payments by the amount of SSDB for which she was eligible, but instead referred her to a law firm that assisted her in submitting an application for SSDB in August 2000. J.A. 145a-46a. In addition to avoiding the estimated reduction, obtaining SSDB was beneficial to Glenn in two significant ways: (1) a recipient of SSDB accrues covered quarters of work for social security retirement benefit purposes (20 C.F.R.

[Footnote continued from previous page]

land Clinic, Cardiac Resynchronization Therapy: The Biventricular Pacemaker Implant Procedure, *at* http://www.clevelandclinic.org/heartcenter/pub/guide/tests/procedures/biventricular_pm.htm.

§ 404.115(c)), and (2) the Plan does not reduce benefits by the SSDB cost-of-living increases. C.A. App. 144. The Social Security Administration (SSA) initially denied Glenn's claim. J.A. 132a. Following a hearing, however, an administrative law judge (ALJ) concluded that, under the relevant Social Security regulations, Glenn was "disabled" effective April 30, 2000. Pet. App. 41a-42a (citing 20 C.F.R. § 404.1520 and 20 C.F.R. § 416.920).

In his April 22, 2002 decision, the ALJ found that, although Glenn was impaired, her impairments were not severe enough to warrant a finding of disability without an inquiry into her ability to perform her prior work and other gainful employment. Pet. App. 44a-45a. Adopting the testimony of a vocational expert, the ALJ concluded that Glenn's medical condition prevented her from performing any of her prior jobs. The burden then "shift[ed] to the Commissioner to show that there are other jobs that the claimant can perform which exist in significant numbers in the economy." *Id.* at 46a. The ALJ found that the Commissioner had not met that burden. *Id.* at 47a.[3]

5. MetLife periodically reevaluated Glenn's eligibility for benefits by sending requests for medical information to Dr. Patel. As Glenn approached the beginning of her third year of benefits, MetLife started to evaluate whether she was eligible to continue to receive benefits under the stricter definition of "Total Disability" operative after the first two

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[3] As provided by the Plan, MetLife thereafter reduced its monthly benefits payments to Glenn by the amount that she was receiving from the SSA, and Glenn reimbursed MetLife for the amount of benefits that she had been overpaid as a result of the retroactive SSDB award.

years of benefits, which requires the claimant to be "totally incapable of performing the material duties of any gainful occupation for which [she is] reasonably qualified." J.A. 160a.

Accordingly, in March 2002, MetLife requested Dr. Patel's opinion on Glenn's ability to return to some form of full-time work. J.A. 57a. Dr. Patel completed a physical capacity evaluation in which he opined that, in an eight-hour workday, Glenn could sit eight hours, stand four hours, and walk two hours. *Id.* at 58a. The evaluation asked whether Glenn was able to work full-time at a sedentary physical exertion level occupation, and Dr. Patel answered "yes." *Id.* Consistent with this answer, when asked to list any physical barriers preventing Glenn from returning to full-time work, Dr. Patel answered "NA." *Id.*

In June 2002, Dr. Patel completed another physical capacity evaluation. J.A. 54a. At that time, he repeated that, in an eight-hour workday, Glenn could sit eight hours and stand four hours. He further indicated that Glenn could now walk from two to four hours per day. *Id.* He also stated that Glenn could lift and carry up to ten pounds occasionally, and that she could use her hands for grasping, pushing, and fine manipulation. *Id.* at 54a-55a. Dr. Patel restricted Glenn from heavy exertion and emotional stress. *Id.* at 55a.

In July 2002, MetLife sent Glenn's records to Dr. Mark Moyer, an independent physician consultant, who concurred with Dr. Patel that Glenn could perform sedentary work. C.A. App. 170. Glenn's file was then referred to a Certified Rehabilitation Coordinator for a transferable skills and labor market analysis (TSA). Taking into account Glenn's educa-

tion, background, and training, and Dr. Patel's physical capacity evaluations and instructions to limit heavy exertion and emotional stress, the Rehabilitation Coordinator found that there were sedentary occupations available in Glenn's geographic area that she was capable of performing and that met her salary requirements, including account information clerk, attendance clerk, and classified ad clerk. J.A. 100a-03a; *see also id.* at 113a.

Based on Dr. Patel's conclusion in the two most-recent physical capacity evaluations, Dr. Moyer's review of Glenn's file, and the results of the vocational TSA, MetLife concluded that Glenn could perform alternative occupations that, unlike her position as a Sears sales manager, were sedentary in nature. Thus, because Glenn was not "totally incapable of performing the material duties of any gainful occupation for which [she was] reasonably qualified," MetLife advised Glenn by letter on July 13, 2002, that she did not meet the stricter definition of "Total Disability" that applies after 24 months, and that her last day of benefits would be September 16, 2002. J.A. 14a-15a.[4]

Glenn requested that MetLife reconsider its decision. J.A. 35a. In support of her reconsideration request, she submitted a letter from Dr. Patel, dated nine days after MetLife's decision, in which he asserted that Glenn continued to have shortness of breath with "moderate exertion" and "continue[d] to have significant difficulty in returning to even any kind of sedentary job because any kind of psychological stress at work causes significant problems with

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[4] Although a file copy of this letter was not retained, there is no dispute that Glenn received it. J.A. 14a-15a, 35a.

her cardiovascular condition." *Id.* at 44a. Dr. Patel further stated (erroneously, as MetLife later learned) that "the patient has tried to return to work in the past with exacerbation of her symptoms," and concluded that Glenn "should not be forced to return to . . . even sedentary work." *Id.* Dr. Patel's letter did not identify any changes in Glenn's medical condition that had caused him to alter his recent opinions that Glenn was fit for sedentary work with low exertion.

Before MetLife fully reevaluated Glenn's eligibility for continued long-term disability benefits, the case management specialist sent her a letter dated August 28, 2002, updating the decision to discontinue her benefits and specifying her review rights. J.A. 29a-33a. Consistent with the conclusion of a nurse consultant that had reviewed Glenn's file (*id.* at 17a-20a), MetLife explained that the new "information submitted" by Glenn did "not change the previous finding" because Glenn's medical records supported Dr. Patel's earlier conclusion that her condition was stable and that she could perform sedentary work. *Id.* at 29a-32a.

Glenn appealed this decision through counsel on February 12, 2003. C.A. App. 191. In support of her appeal, Glenn submitted yet another letter from Dr. Patel, in which he asserted that, even though he had previously reported that Glenn was fit for sedentary work, there was "never a time" when he felt Glenn "would be able to return to full-time employment." J.A. 42a. He also maintained that her new cardiac device had no role in "improving her cardiac function" and was only meant to provide defibrillation in the event of sudden cardiac death (*id.*)—a perplexing statement given that Dr. Patel himself had previously noted that Glenn's new cardiac device also included biventricular pacing (*id.* at 71a, 75a),

which can significantly improve heart function. *See supra* pg. 5 n.2.

MetLife then referred Glenn's records to Dr. Chandrakant Pujara, an independent board-certified cardiologist. Dr. Pujara observed that, as a result of "appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status." J.A. 39a. He also stated that Glenn "has been relatively free of any significant cardiac decompensation as documented by Dr. Patel's follow up notes." *Id.* at 38a. Given these factors, Dr. Pujara concluded that, although the impact of emotional stress on Glenn was difficult to gauge, Glenn was "a reasonable candidate to try one of the sedentary job classes at least on a trial basis" and that her work capacity should continue to improve with the use of biventricular pacing. *Id.* at 39a.

Based on the entirety of the medical and vocational record before it, MetLife rejected Glenn's appeal. In a letter dated May 20, 2003, detailing Glenn's objective medical records, MetLife explained that "the documentation currently in the file"—including, specifically, Dr. Patel's letter of February 12, 2003—did not support a disability as defined in the Plan. J.A. 25a-26a.

6. Having exhausted her administrative remedies, Glenn filed suit in the United States District Court for the Southern District of Ohio seeking benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

The district court granted MetLife's motion for summary judgment. As required by binding Sixth Circuit precedent, the district court first ruled that the fact that MetLife both evaluated and paid claims constituted a "conflict of interest" that had to be

"considered as a factor when applying the abuse of discretion standard." Pet. App. 34a. "[C]onsider[ing] and weigh[ing] this factor throughout" its analysis (*id.*), the district court nevertheless upheld MetLife's determination that Glenn is not eligible for benefits under the stricter Plan standard for "Total Disability" applicable after 24 months. In light of Dr. Patel's conclusion in his physical capacity evaluations that Glenn was capable of performing sedentary work, the similar findings of Drs. Moyer and Pujara, and the vocational TSA, the court concluded that there was "substantial evidence supporting MetLife's determination that [Glenn] was no longer totally disabled as the Plan defines that term." *Id.* at 40a. The court explained that, because "Dr. Patel expressly acknowledged that he had stated that plaintiff was fit for sedentary work" in his February 12, 2003 letter, "MetLife did not abuse its discretion by viewing Dr. Patel's recantation with skepticism." *Id.* at 39a. The court also concluded that the SSA decision awarding benefits to Glenn did not undermine MetLife's reasoning because "the records before the ALJ and MetLife were materially different." *Id.* at 36a.

7. The Sixth Circuit reversed. Like the district court, the court of appeals held that the fact that MetLife both evaluated and paid claims constituted a "conflict of interest" that was a "relevant factor in determining whether an abuse of discretion had taken place." Pet. App. 10a. According to the court of appeals, however, the district court had given insufficient "weight" to that conflict in reviewing MetLife's decision to terminate Glenn's benefits. *Id.*

Although it purported to apply an abuse-of-discretion standard of review, the court of appeals then conducted an in-depth review of Glenn's history,

highlighting and emphasizing information favorable to Glenn while minimizing or ignoring contrary evidence. Among other things, the court faulted MetLife for "fail[ing] to address Social Security's contrary determination of Glenn's status." Pet. App. 11a. The court of appeals also criticized MetLife for crediting the two physical capacity evaluations in which Dr. Patel stated that Glenn could return to work in a sedentary capacity, and "fail[ing] to give any weight to Dr. Patel's letters of July 22, 2002, and February 12, 2003, in which he clearly stated that he did not believe Glenn was capable of returning to work." *Id.* at 15a. Conceding that "Dr. Patel's opinion of Glenn's ability to perform sedentary work has not been consistently expressed" (*id.* at 23a)—but failing to acknowledge that Dr. Patel had changed his opinion only after MetLife had terminated Glenn's benefits and without identifying any change in Glenn's medical condition—the court of appeals found that "the only fair inference from the record would undercut" the "aberrational" evaluations in which Dr. Patel indicated that Glenn was able to undertake sedentary work. *Id.* at 16a, 20a.

The court of appeals concluded, "Taken together, these factors reflect a decision by MetLife that can only be described as arbitrary and capricious," and it therefore ordered the reinstatement of Glenn's disability benefits. Pet. App. 25a.

SUMMARY OF ARGUMENT

I. The language, history, and purpose of ERISA establish that an entity that acts as a fiduciary when evaluating claims does not act under a conflict of interest that must be considered on judicial review merely because it has separately agreed in a nonfi-

duciary capacity to fund the benefits paid by the Plan by issuing a group insurance policy.

A. ERISA explicitly authorizes plan fiduciaries to evaluate and pay claims (29 U.S.C. § 1108(c)(3)) and thereby establishes that this consolidation of functions within a single entity, standing alone, does not place fiduciaries in the prohibited position of "deal[ing] with the assets of the plan in [their] own interest." *Id.* § 1106(b)(1). Weighing the fact that the same entity both evaluates and pays claims on judicial review in the absence of any evidence in the administrative record that the fiduciary acted improperly would conflict with these provisions of ERISA and with this Court's conclusion that a fiduciary may have "financial interests adverse to beneficiaries" as long as it does not act upon those interests when making fiduciary decisions. *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

This conclusion is confirmed by the trust-law principles that served as the backdrop for ERISA's enactment. Where a conflict of interest is contemplated in the trust documents, trust law does not generally weigh that conflict on judicial review. Such a conflict is relevant, if at all, only if the plaintiff is able to make a showing that the fiduciary's decision was actually infected by self-dealing.

Changing the plan settlor's intended arbitrary-and-capricious standard of review merely because—as Congress also contemplated—the entity that determines eligibility also pays the claims would undermine ERISA's objectives of promoting prompt, efficient, and cost-effective plan administration. It is far more efficient to have a single company that issued the funding mechanism based on the plan design evaluate a benefit claim under those plan terms

than to divide those functions between two separate companies. Moreover, changing the standard of judicial review merely because entities in MetLife's position separately perform these two functions will encourage participants with dubious claims to file suit in the hope that a heightened standard of review and the burdens of conflict-of-interest discovery will produce a settlement, or that the diluted standard will persuade a court to second-guess a plan's reasonable benefit determination. The costs associated with this administrative inefficiency and increased litigation will increase premiums or diminish the generosity of plan designs, as well as deter employers from forming new, or continuing existing, benefit plans.

B. The realities of benefit plan administration confirm that companies that act as fiduciaries and separately fund claims through group insurance policies do not operate under a conflict of interest that should affect the standard of judicial review. As several circuits have recognized, insurance companies and the employers who sponsor ERISA-regulated plans share strong commercial incentives to treat claimants fairly and to pay meritorious claims. Moreover, the claims reviewers making benefit determinations do not have financial interests adverse to claimants because they are salaried employees whose income does not vary based upon denials, and because, in making such determinations, they are bound by their fiduciary obligation under ERISA to act "solely in the interest" of plan participants. 29 U.S.C. § 1104(a)(1). Indeed, such potential, theoretical conflicts abound in other areas of the law, but this Court has nonetheless determined that employees should not be presumed to be biased in favor of their employer (*Richardson v. Perales*, 402 U.S. 389, 410 (1971) (administrative law)) and that the plain-

tiff must make a threshold showing of improper motive (*United States v. Armstrong*, 517 U.S. 456, 468 (1996) (criminal prosecutions)). These standards should also apply in the ERISA setting.

C. Participants' interests are adequately protected even without a heightened standard of review. Improperly motivated decisions will almost invariably be reversed under the usual abuse-of-discretion standard because ERISA's requirement that a fiduciary document the basis for its claims determinations makes it exceedingly difficult to conceal self-interested decision-making. Moreover, the fiduciary obligations imposed by ERISA are in addition to, and do not displace, regulation by various state departments of insurance. *See, e.g.*, 29 U.S.C. § 1144(b)(2)(A); *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003). State regulation and Department of Labor procedural safeguards provide participants with strong protection against improperly-motivated benefit determinations.

Because the provisions of the Sears Long Term Disability Plan contemplate that MetLife will both evaluate and pay claims, and Glenn produced no evidence that MetLife was motivated by its own self-interest when terminating her benefits, the decision below should be reversed.

II. If the Court concludes that the fact that a company both evaluates and pays claims should affect the standard for judicial review, that conflict should be weighed as only one factor in determining whether the company abused its discretion.

A. This Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), indicates that a conflict of interest, if a cognizable conflict exists, is merely one factor to be considered in deter-

mining whether a fiduciary abused its discretion. That approach is more consistent with ERISA's trust-law underpinnings and the objectives that animate the statute than the alternative approaches sometimes employed by the courts of appeals. If the Court concludes that the fact that a company both evaluates and pays claims must be weighed on judicial review, it should also make clear that such an arrangement warrants *de minimis* weight on judicial review in all but the most egregious factual circumstances.

B. Although the Sixth Circuit purported to apply the abuse-of-discretion standard that this Court endorsed in *Firestone*, it actually undertook a *de novo* review of MetLife's determination when it reweighed the evidence, emphasized the factors that favored Glenn, and accorded no weight to compelling contrary evidence, much less any deference to MetLife's decision. The Sixth Circuit's decision should therefore be reversed even if the fact that MetLife both evaluated and paid claims is relevant on judicial review.

As an initial matter, even if some weight were appropriate, the court of appeals gave undue weight to the fact that MetLife both evaluates and pays claims. There is no evidence that this purported conflict of interest in any way affected MetLife when it concluded that Glenn was not eligible for long-term disability benefits under the strict standard set forth in the Plan. Indeed, that decision was fully substantiated by the medical file, which included five assessments in which her own treating physician and independent physicians concluded that Glenn was capable of performing sedentary work.

The court of appeals also erred by requiring MetLife to provide a written refutation of the SSA disability determination. That requirement contravenes this Court's holding in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), that courts may not impose a discrete "burden of explanation" when claim administrators reject a claimant's evidence. *Id.* at 834. Moreover, the SSA determination was based on different medical evidence than MetLife's decision to terminate Glenn's benefits, and was fully consistent with that decision.

The court of appeals also impermissibly second-guessed MetLife's resolution of the "conflict" between Dr. Patel's physical capacity evaluations and the revised assessments he submitted after MetLife terminated Glenn's benefits. In fact, the court of appeals completely ignored the crucial timing of the treating physician's changed conclusion. MetLife reasonably concluded that the medical evidence established that Glenn was not disabled, despite Dr. Patel's revised assessment, because that assessment contradicted his prior consistent physical capacity evaluations and the opinions of three other physicians.

ARGUMENT

In the wake of this Court's holding in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that ERISA plan fiduciaries' discretionary benefit determinations should be reviewed for an abuse of discretion, lower courts have struggled with whether an entity that both evaluates and pays claims should be deemed to operate under a "conflict of interest" that should alter, or otherwise be factored into, the standard for judicial review. Some courts—such as the Sixth Circuit in the decision below—have held that these fiduciaries always operate under a conflict

of interest that should be weighed on judicial review (Pet. App. 10a); others have held that this fact is generally irrelevant on judicial review (*see, e.g., Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999)); and a third group has held that the factor should be considered on judicial review only if the plaintiff is able to demonstrate that the conflict of interest actually influenced the benefit determination (*see, e.g., Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000); *Sahulka v. Lucent Techs., Inc.*, 206 F.3d 763, 768 (8th Cir. 2000)).

Where a fiduciary is found to be operating under a conflict of interest, the lower courts have also adopted differing means of weighing that conflict on judicial review. Most lower courts have adopted variations of the so-called "sliding scale" standard, under which the degree of deference afforded to the fiduciary depends on the seriousness of the conflict. *See, e.g., Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006) (en banc) (disclaiming the "sliding scale" label but advocating a "similar" approach in some cases); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 587 (8th Cir. 1999). Other courts, however, shift the burden of proof to a conflicted fiduciary to establish the reasonableness of its decision. *See Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004); *HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-95 (11th Cir. 2001). And at least one court utilizes *de novo* review to examine a decision by a conflicted fiduciary. *See Pulvers*, 210 F.3d at 91. *But see Abatie*, 458 F.3d at

973 (court may consider new evidence under abuse-of-discretion review).

The circuits' consideration of these questions since *Firestone* has produced several useful insights. First, as recognized by the Seventh and Eighth Circuits, among others, the standard of review required by the plan's delegation of discretionary authority should not change merely because a *potential* conflict exists that was also contemplated by ERISA. Second, as suggested by the majority view, an actual conflict (as distinguished from the potential conflict here) should be weighed as part of abuse-of-discretion review; it should not shift the burden of proof or produce *de novo* review.

I. A COMPANY THAT BOTH EVALUATES AND PAYS CLAIMS, WITHOUT MORE, DOES NOT OPERATE UNDER A CONFLICT OF INTEREST THAT MUST BE WEIGHED ON JUDICIAL REVIEW.

The Sixth Circuit held that the fact that the same entity both evaluates and pays claims should *always* be weighed on judicial review of a fiduciary's benefit determination. That conclusion cannot be reconciled with the language or purpose of ERISA, its trust-law underpinnings, or the realities of benefit plan administration. Each of these interpretive guideposts establishes that, where a company both evaluates and pays claims, this fact, standing alone, should only affect judicial review where the plan settlor does not contemplate this consolidation of functions or where the plaintiff is able to make a substantial showing from the administrative record or public sources that the fiduciary's benefit determination was actually infected by a conflict of interest.

A. The Language, Structure, And Purpose Of ERISA Establish That A Company That Evaluates And Pays Claims Does Not For That Reason Alone Operate Under A Conflict Of Interest That Must Be Weighed On Judicial Review.

1. As this Court has repeatedly noted, ERISA establishes a "comprehensive and reticulated" legal framework governing employee benefit plans. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993) (internal quotation marks omitted). ERISA addresses in detail the subject of prohibited transactions by fiduciaries, and expressly prohibits a fiduciary from "deal[ing] with the assets of the plan in his own interest." 29 U.S.C. § 1106(b)(1). ERISA also expressly *authorizes* an employer—or any agent of the employer—responsible for funding a benefit plan to serve in a fiduciary capacity as claim administrator. *See id.* § 1108(c)(3); *see also id.* § 1002(14)(C). ERISA even requires employers to serve as default plan administrators in certain circumstances. *See id.* § 1002(16)(A)(ii). Congress therefore made clear that it did not consider a fiduciary that is separately responsible for paying the claims that it reviews to be acting "in [its] own interest." In the case of fiduciaries that are also insurance providers, Congress carefully preserved the existing state regulatory schemes (*id.* § 1144(b)(2)(A)), adding to that oversight the heavy obligations of a fiduciary.

It cannot be the case that an arrangement that was expressly contemplated—and authorized—by Congress, without more, changes the standard of review for discretionary benefit determinations. Congress's decision to provide express authorization for employers to fund and administer pension plans—a

common-place arrangement of which Congress was well-aware when it enacted ERISA—reflects its judgment that a fiduciary's theoretical financial interest in a benefit determination does not, standing alone, constitute a conflict of interest that should affect the standard of review. *See* Staff of Senate Comm. on Labor and Public Welfare, 92d Cong., 2d Sess., Statistical Analysis of Major Characteristics of Private Pension Plans 31-32 (Comm. Print 1972) (finding that sixty percent of participants in private pension plans belonged to employer-administered plans and that some of these plans were unfunded). It defies logic to suggest that, when "enact[ing] ERISA to protect . . . the interests of participants in employee benefit plans" (*Davila*, 542 U.S. at 208 (internal quotation marks omitted; ellipsis in original)), Congress would have expressly permitted the same entity to evaluate and pay claims if it believed that vesting both responsibilities in a single body would create a conflict of interest detrimental to plan participants.

This conclusion is confirmed by *Pegram v. Herdrich*, 530 U.S. 211 (2000), which acknowledged that ERISA authorizes a fiduciary to "have financial interests adverse to beneficiaries." *Id.* at 225. The Court explained that ERISA does not prohibit a fiduciary from owning "two hats"—such as that of plan fiduciary and plan funding source. ERISA instead requires that a "fiduciary with two hats wear *only one at a time*, and wear the fiduciary hat when making fiduciary decisions." *Id.* (emphasis added). Based on these statutory principles, the Court held that a health maintenance organization could not have breached its fiduciary duty to act solely in the interest of plan beneficiaries when its physician owners made medical treatment decisions under a

framework that enabled the physicians to profit from a decision to minimize medical care, because the physicians were not acting in a fiduciary capacity when making such decisions.

Because ERISA permits a fiduciary to have "financial interests adverse to beneficiaries" (*Pegram*, 530 U.S. at 225) and expressly authorizes the consolidation of claim administration and funding responsibilities within the same entity, the fact that the same company has employees who sell group insurance policies that fund plans and others who determine eligibility—and may therefore derive a financial benefit from a claim denial—cannot be weighed on judicial review unless the plaintiff makes a showing that the fiduciary in fact acted on the basis of its own financial interests when carrying out its fiduciary responsibilities.

2. The trust-law principles that served as the backdrop for the enactment of ERISA confirm that, without more, the fact that the same entity both evaluates and pays claims does not create a conflict of interest that must be weighed on judicial review. *See Firestone*, 489 U.S. at 110-11 (because "ERISA abounds with the language and terminology of trust law," the Court must look to "principles of trust law" "[i]n determining the appropriate standard" for reviewing benefit determinations); *see also Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc.*, 472 U.S. 559, 570 (1985).

Under traditional trust-law principles, trustees may serve in settings where their decisions could *potentially* further their own interests, as long as that arrangement is contemplated in the trust documents. *See, e.g.*, Restatement (Second) of Trusts (1959) § 170

cmt. t ("By the terms of the trust the trustee may be permitted to sell trust property to himself individually, or as trustee to purchase property from himself individually, or to lend to himself money held by him in trust, or otherwise to deal with the trust property on his own account.").[5] Where such a potential conflict was contemplated by the settlor, courts do not weigh that conflict in reviewing trustees' decisions because it is "the administration of the trust, not potential conflicts, [that] determine[s] if the trustees have acted in the best interests of the trust beneficiaries." *Delaware v. Belin*, 456 So. 2d 1237, 1241 (Fla. Dist. Ct. App. 1984). Indeed, this Court has explained that "it is a settled principle that trustees having the power to exercise discretion will not be interfered with so long as they are acting bona fide. To do so would be to substitute the discretion of the court for that of the trustee." *Shelton v. King*, 229 U.S. 90, 94-95 (1913). Courts thus continue to "presume[ ] that a trustee" "has acted in good faith" despite such a potential conflict, unless there is some

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[5] *See also* G.G. Bogert & G.T. Bogert, *The Law of Trusts and Trustees* § 543(U), at 373 (rev. 2d ed. 1978) (most commonly recognized exception to application of rule against conflicts of interest is where the settlor has approved the self-dealing transaction or conflict-of-interest position); Mark L. Ascher et al., *Scott and Ascher on Trusts* § 17.2 (5th ed. 2007) (if trust authorizes trustee to undertake certain transaction, trustee may ordinarily do so without fear of liability, notwithstanding that the transaction involves self-dealing or a conflict of interest); *Estate of Fruehauf v. Comm'r*, 427 F.2d 80, 86 (6th Cir. 1970) (holding that a widower who served as both executor and trustee of his deceased wife's estate could convert trust property into his personal property because the trust document allowed him to do so); *In re Estate of Thompson*, 328 P.2d 1, 3 (Cal. 1958); *Rosencrans v. Fry*, 95 A.2d 905, 913 (N.J. 1953).

affirmative evidence to the contrary. *Gregory v. Moose*, 590 S.W.2d 665, 670 (Ark. Ct. App. 1979).[6]

Trust law therefore confirms what is apparent from ERISA's own provisions: The fact that a plan fiduciary has a potential conflict of interest contemplated in the plan documents should only be weighed on judicial review if a plaintiff is able to make a showing that the fiduciary was actually infected by self-dealing when making the challenged decision.

This conclusion is consistent with the Court's decision in *Firestone*.[7] Relying on the Restatement (Second) of Trusts, the Court observed that, if an administrator "is *operating*" under a conflict of interest, then such a "conflict must be weighed as a 'facto[r] in determining whether there is an abuse of

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[6] *See also Goldman v. Rubin*, 441 A.2d 713, 725 (Md. 1982) (reversing a trial court's decision because, "[b]y emphasizing the conflict of interests, which we have concluded was intended and authorized, the trial court did not reach an analysis of the fiduciaries' position under a standard of discretionary action"); *Estate of Gilliland*, 140 Cal. Rptr. 795, 802 (Ct. App. 1977); *In re Estate of Alexander*, 171 S.W.3d 794, 796-97 (Mo. Ct. App. 2005); *In re Pincus' Estate*, 105 A.2d 82, 86 (Pa. 1954); *In re Estate of Halas*, 568 N.E.2d 170, 178 (Ill. App. Ct. 1991); *Huntington Nat'l Bank v. Wolfe*, 651 N.E.2d 458, 465-66 (Ohio Ct. App. 1994).

[7] In *Firestone*, this Court reviewed the Third Circuit's holding that a benefit determination by a fiduciary that both evaluates and pays claims should be subject to *de novo* review "given the lack of assurance of impartiality on the part of the employer." 489 U.S. at 107-08 (citing 828 F.2d 134, 137-45 (3d Cir. 1987)). The Court did "not rest [its] decision on the concern for impartiality that guided the Court of Appeals," but instead concluded that *de novo* review was appropriate for all benefit determinations "unless," as here, "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115.

discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d) (alteration in original; emphasis added). In making this statement, the Court did not purport to determine which categories of conflicts of interest should be taken into account on judicial review. Indeed, the illustrations provided by the Restatement suggest that the Court was referring to conflicts of interest that have actually infected the trustee's determination. *See* Restatement (Second) of Trusts § 187 cmt. g illus. 2-4 (an action is motivated by an improper purpose such as a conflict of interest or a religious bias where the trustee's decision was based "solely on the [improper] ground"). Whatever role an *actual* conflict such as that described in the Restatement should play in judicial review, ERISA and its trust-law underpinnings establish that a *potential* conflict contemplated by the plan settlor when delegating discretion should not change the abuse-of-discretion standard where there is no affirmative evidence that the fiduciary acted upon that conflict.

3. Any change in the intended standard of review based on the mere fact that the same entity reviews and pays claims—as contemplated by the plan—would also contradict the dual policies underlying ERISA.

Congress designed ERISA to protect the interests of plan participants and to facilitate the formation of employee benefit plans by "minimizing the administrative and financial burdens on plan administrators." *Egelhoff*, 532 U.S. at 150 (internal quotation marks omitted). The consolidation of claims administration and funding responsibilities within a single company promotes both of these objectives because allocating multiple administrative responsibilities to a single entity facilitates the development of an effi-

cient claims-processing and payment procedure. The cost-savings associated with the consolidation of claims processing and payment responsibilities in a single company preserve finite resources for stabilizing premiums or providing more generous benefit plans, and may encourage the formation of more employee benefit plans. As the United States correctly argued in *Pegram*, "ERISA . . . tolerates the level of divided loyalty that is intrinsic to those common arrangements [under which insurers make benefit determinations], so that ERISA plans will be created and insurance companies and others will find it practical to work for them." Br. for the United States as *Amicus Curiae* at 28, *Pegram* (No. 98-1949); *see also* 120 Cong. Rec. H8702 (daily ed. Aug. 20, 1974) (statement of Rep. Ullman upon introducing the conference report) (it is "axiomatic" that "plans cannot be expected to develop if costs are made overly burdensome").

On the other hand, treating such common-place arrangements, without more, as a "conflict" that dilutes the standard of review intended by the plan settlor will inevitably encourage participants with dubious claims to file suit in the hope of convincing a court to second-guess the plan's claim determination.[8]

The undiluted abuse-of-discretion standard of review that is intended by plan documents deters ques-

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[8] If the fact that the same entity both evaluates and pays claims is sufficient, without more, to heighten the standard of review, fiduciaries may shade their claim determinations in favor of individual claimants who would otherwise not qualify for benefits in order to avoid expensive and protracted litigation, thereby reducing the funds available for the payment of meritorious benefits claims.

tionable filings—and shields plans from the costs of unwarranted litigation—by preventing a plan's reasonable claim determination from being overturned simply because record evidence supports both sides of the issue. *See Gall v. United States*, 128 S. Ct. 586, 597 (2007). Application of this deferential standard of review makes eminent sense in the context of discretionary claim determinations because plan fiduciaries have much more extensive experience reviewing the merits of such claims than do federal courts. *Cf. Koon v. United States*, 518 U.S. 81, 98 (1996). This Court has acknowledged, however, that "[i]t is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002). If courts are required to dilute the applicable deferential standard merely because the same entity both evaluates and pays claims, they may use this purported conflict of interest—either knowingly or unknowingly—as a basis for substituting their own evaluation of the medical evidence for plan fiduciaries' reasonable benefit determinations.

ERISA reflects Congress's "desire not to create a system that is so complex that . . . litigation expenses[ ] unduly discourage employers from offering welfare benefit plans." *Varity Corp*, 516 U.S. at 497. Indeed, ERISA seeks to facilitate cost-effective dispute resolution through internal administrative review rather than litigation. *See* 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(h)(1). Increasing the litigation burdens on ERISA plans will drain their limited financial resources and discourage employers from establishing benefit plans—to the substantial detriment of existing and prospective plan participants and beneficiaries. This Court should not lightly re-

write the deferential standard that the plan settlor envisioned when it delegated discretionary authority to the claim fiduciary, solely on the basis of a potential conflict that was also contemplated by the plan, and thus invite wasteful litigation that can only diminish the assets that are ultimately available to provide and fund benefits.

B. The Realities Of The Insurance Business Confirm That A Company That Evaluates And Pays Claims Does Not Operate Under A Conflict Of Interest That Must Be Weighed On Judicial Review.

Congress's decision to provide express authorization for ERISA plan fiduciaries to evaluate and pay claims alsc reflects its understanding that the practical realities of the insurance business impose significant checks upon fiduciaries that simultaneously perform these functions.

Any potential conflict inherent in an insurance company's evaluation and payment of claims is counterbalanced by the fact that insurers have powerful long-term business incentives to treat claimants fairly. Employers are not required to provide welfare benefits to their employees (*Spink*, 517 U.S. at 887), but many employers do so to attract talent and boost employee morale. Insurers who routinely deny meritorious claims will inevitably anger participants and, in turn, alienate their employers, who—having made the decision to fund a welfare benefit plan—want to ensure that their financial investment has the intended effect of increasing employees' job satisfaction. *See Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998) ("employers want to see their employ-

ees' claims granted because they want their employees satisfied with their fringe benefits"). Indeed, as several courts have noted, individual claims are often quite minute when compared with the profitability of the supposedly conflicted decision-makers (*see Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995)), who are unlikely to risk their goodwill—and endanger their prospects of securing repeat business—by not treating claimants fairly (*Wright*, 402 F.3d at 75); *see also Group Insurance* 24 (William F. Bluhm et al. eds., 4th ed. 2003) ("Organizations cannot survive if they must focus their sales efforts on replacing dissatisfied customers."). These long-run reputational incentives for insurance companies to review benefit claims in an equitable manner counteract the purely theoretical short-term interest that a company may have to minimize payouts by denying meritorious claims.

Moreover, it is overly simplistic to think that, where an insurance company is responsible for evaluating and paying claims, every dollar that the insurance company pays in benefits comes directly out of its profits. Ordinarily, the premium that a plan sponsor or the participants pay is calculated using actuarial assumptions that allow the insurance company to pay meritorious claims while still earning a profit considered to be reasonable by state regulators. *See generally* S. Haberman & E. Pitacco, Actuarial Models for Disability Insurance (1999). *See also* Cal. Code Regs. tit. 10, § 2214; N.Y. Comp. Codes R. & Regs. tit. 11, § 52.40. If those assumptions prove incorrect, the insurance company will adjust the premium in future years to reflect more accurately the cost of paying benefit claims. Various underwriting approaches, rate-setting mechanisms, and reserving and investment practices, all of which

involve actuaries, underwriters, investment specialists and regulatory oversight, make the business of insurance significantly more complex than may appear at first blush. *See, e.g., Group Insurance, supra,* at 655-712. The assumption of the United States that "every exercise of discretion impacts [the fiduciary] financially, filling or depleting its coffers" (U.S. Cert. Br. 13 (internal quotation marks omitted)) is thus overly simplistic.

Furthermore, the insurance company employees who actually make benefit determinations do not have direct personal stakes in the outcome of their decisions. Indeed, this Court has recognized that a person's interests are not defined simply by the source of his paycheck. *See Polk County v. Dodson,* 454 U.S. 312, 319 (1981) (holding that a public defender is not a state actor simply because he is paid by the State). Administrative law judges, for example—who are often salaried employees of the agencies appearing before them—are not considered to be operating under a conflict of interest when presiding over adversarial proceedings between their agency-employer and a third party. In *Richardson v. Perales,* 402 U.S. 389 (1971), the Court concluded that a social security hearing examiner is not biased against a claimant simply because he is a government employee "charged with developing the facts." *Id.* at 410. The Court emphasized that the allegations of bias "assume[d] too much" because, without any evidentiary substantiation, they ascribed improper motives to a hearing examiner based on a procedural structure that was common throughout many government programs. *Id.*; *see also Withrow v. Larkin,* 421 U.S. 35, 52 (1975) ("our cases . . . offer no support for the bald proposition . . . that agency

members who participate in an investigation are disqualified from adjudicating").

Like a social security examiner, an insurance company claims administrator is not an advocate on behalf of his employer; rather, "[h]e acts as an examiner charged with developing the facts" and making a benefit determination on the basis of those facts. *Perales*, 402 U.S. at 410. In reaching a decision, the claims administrator is bound by his fiduciary obligation to discharge his responsibilities "solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1).

Accordingly, as at trust law, a claims fiduciary operating under a contemplated conflict of interest must be "presumed" to act in accordance with this fiduciary obligation, even if his employer also pays a participant's benefits. *Gregory*, 590 S.W.2d at 670 ("it is presumed that a trustee has acted in good faith and the burden of proof rests upon those who question his actions"). Indeed, as this Court has recognized in other settings, courts should not presume that decision-makers are motivated by improper considerations without a substantial evidentiary showing to that effect. *United States v. Chem. Found., Inc.*, 272 U.S. 1, 14-15 (1926). In *United States v. Armstrong*, 517 U.S. 456 (1996), for example, the Court refused to allow discovery into whether a prosecutor's decisions were improperly motivated by race where the defendant had failed to make an "appropriate threshold showing" that the prosecutor declined to prosecute similarly-situated persons of other races. *Id.* at 463. The Court emphasized that prosecutors' charging decisions are inherently discretionary, and that discovery into the prosecutor's motives would "divert . . . resources" and impose significant constraints on charging discretion. *Id.* at 468.

A threshold showing of probative evidence was necessary to "adequately balance[ ]" the prosecutor's interest in exercising his discretion and the defendant's interest in race-neutral prosecutorial decisions. *Id.* at 470.

A similar rule is appropriate in the ERISA context. A claim that a company was conflicted because it both evaluated and paid claims should fail in the absence of a showing that the company's decision was actually infected by that potential "conflict." Indeed, this Court has made clear that "any conflict of interest on the plan fiduciary's part" is relevant on judicial review *only* where the "conflict was plausibly raised." *Rush Prudential*, 536 U.S. at 384 n.15.

Fiduciaries should therefore be presumed to faithfully discharge their obligations in the absence of an appropriate showing from the administrative file indicating that the fiduciary's decision was actually based on an improper motive. Restatement (Second) of Trusts § 187 cmt. g ("Although ordinarily the court will not inquire into the motives of the trustee, yet if it is shown that his motives were improper or that he could not have acted from a proper motive, the court will interpose.").[9]

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[9] *See also Jarvis v. Boatmen's Nat'l Bank*, 478 S.W.2d 266, 273 (Mo. 1972) ("The presumption is that a trustee has acted in good faith and the burden is on the one questioning his actions and seeking to establish a breach of trust to prove the contrary."); *Rice v. Peoples Sav. Bank*, 247 P. 1009, 1011 (Wash. 1926) ("The presumption is that a trustee will faithfully administer his trust . . . .") (internal quotation marks omitted).

C. Participants' Interests Are Fully Protected When Their Claims Are Reviewed By Insurers That Both Evaluate And Pay Claims.

This conclusion finds further support in the extensive protections available under federal and state law for participants whose benefit determinations are made by insurers that both evaluate and pay claims.

1. Under the usual abuse-of-discretion standard, an ERISA fiduciary's discretionary benefit determination may be reversed if it is "arbitrary, capricious, or made in bad faith, not supported by substantial evidence, or erroneous on a question of law." *Music v. W. Conference of Teamsters Pension Trust Fund*, 712 F.2d 413, 418 (9th Cir. 1983) (internal quotation marks omitted). This standard—whether termed "abuse of discretion" review or "arbitrary and capricious" review—closely resembles the standard articulated in the Administrative Procedure Act for review of agency determinations. 5 U.S.C. § 706(2); *see also Block v. Pitney Bowes Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992) (R.B. Ginsburg, J.). Although that standard is "deferential," it does not require a court merely to "rubber-stamp[ ] the result." *Torres v. UNUM Life Ins. Co. of Am.*, 405 F.3d 670, 680 (8th Cir. 2005); *see also Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771, 774 (7th Cir. 2003) (even under a deferential standard of review, "deference need not be abject").

The abuse-of-discretion standard is sufficient to identify virtually all improperly motivated claim determinations because [illegible] decisions invariably rest

on faulty reasoning and inadequate support.[10] Whenever a claim for benefits is denied, the claim administrator must set forth in writing the specific reasons for the denial, describe any additional material or information necessary for the employee to perfect the claim, and explain why that material or information is necessary. 29 U.S.C. § 1133(1). These documentation requirements make it exceedingly difficult for administrators to conceal an arbitrary or capricious decision, and thus significantly reduce the likelihood that administrators will act on the basis of their own financial interests. *Cf. Wolff v. McDonnell*, 418 U.S. 539, 565 (1974) ("the provision for a written record helps to insure that administrators, faced with possible scrutiny by state officials and the public, and perhaps even the courts . . . will act fairly"). Accordingly, even without weighing a potential "conflict of interest," the faulty reasoning offered in an attempt to justify an inappropriate denial of a meritorious claim will inevitably result in a finding that

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[10] *See, e.g., Morgan v. UNUM Life Ins. Co. of Am.*, 346 F.3d 1173, 1177-78 (8th Cir. 2003) (insurer knew before awarding benefits that the claimant routinely engaged in the type of activities the insurer later used as the basis for discontinuing his benefits and insurer's physician lacked experience with respect to claimant's condition); *Zuckerbrod v. Phoenix Mut. Life Ins. Co.*, 78 F.3d 46, 50 (2d Cir. 1996) (denial of partial benefits reversed because it was not supported by substantial evidence); *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914, 919 (7th Cir. 2003) (overturning a plan's benefit determination because there were "mere scraps" of evidence supporting its denial of benefits); *Marecek v. BellSouth Servs., Inc.*, 49 F.3d 702, 706-07 (11th Cir. 1995) (denial of benefits was erroneously based on unsustainable "factual findings and *post hoc* explanations"); *Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 22 (1st Cir. 2005) (claims process was so tainted as to be arbitrary and capricious).

the decision is arbitrary and capricious on judicial review.

The protection afforded to participants by abuse-of-discretion review is reinforced by the Department of Labor's extensive procedural regulations governing ERISA benefit determinations. 29 C.F.R. § 2560.503-1. Those regulations require that a benefit plan "provide a claimant with a reasonable opportunity for a full and fair review of . . . [an] adverse benefit determination." *Id.* § 2560.503-1(h)(2). That review must be performed by someone other than the individual who conducted the initial benefit determination and may not afford deference to that initial decision. *Id.* § 2560.503-1(h)(3)(ii). As part of that review, the fiduciary *must* "consult with a health care professional who has appropriate training and experience in the [relevant] field of medicine" (*id.* § 2560.503-1(h)(3)(iii); *id.* § 2560.503-1(h)(4)), "take[ ] into account all comments, documents, records, and other information submitted by the claimant" (*id.* § 2560.503-1(h)(2)(iv)), and, when upholding a denial of benefits, provide the "specific reason or reasons for the adverse determination" (*id.* § 2650.503-1(j)(1)). These procedural measures provide additional safeguards against biased decision-making by fiduciaries and ensure that self-interested claims determinations will be apparent from the face of the decision itself.[11]

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[11] Where a fiduciary has failed to adhere to the Department of Labor's procedural requirements—or to other procedural standards imposed by ERISA or the terms of the plan itself—a court should require the fiduciary to reconsider its benefit determination in accordance with the full panoply of procedures to which it is required to adhere. *Cf. Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 744 (1985) ("if the agency has not considered all

2. State and federal regulation of insurers provides another layer of protection for plan participants.

ERISA expressly saves state laws that regulate insurance from preemption. 29 U.S.C. § 1144(b)(2)(A); *see also Ky. Ass'n of Health Plans, Inc.*, 538 U.S. at 341-42. In enacting this savings clause, Congress signaled that it is the province of state insurance departments—not federal courts applying ERISA—to oversee and systematically examine insurance practices, including claims processing. Where necessary, these state departments are free to impose extensive remedial measures to correct insurers' wrongdoing. In 2003 and 2004, for example, three state insurance regulators, acting on behalf of their own States and a number of other States, conducted a coordinated investigation of an insurance company based on complaints of biased and irregular decision-making in the company's processing of disability claims.[12] In a settlement with the States, the company agreed to make changes to its claims reviewing procedures and its corporate governance structure, to reassess more than 200,000 claims, and to pay a $15 million fine. Specifically, the company agreed to increase the number of experienced claims

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relevant factors, . . . the proper course, except in rare circumstances, is to remand to the agency for additional investigation or explanation"); *INS v. Ventura*, 537 U.S. 12, 17 (2002) (same). Indeed, courts are much better equipped to police fiduciaries' compliance with procedural requirements than to make benefit determinations themselves.

12 *See* Me. Bureau of Ins., Report of the Targeted Multistate Market Conduct Examination, *at* http://www.maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm.

professionals; involve upper management more heavily in the approval of claims denials; modify its policies regarding medical information, including guidelines for the use of independent medical evaluations; and add a position of quality compliance consultant to assess the totality of its claims decisions and focus on issues of compliance and documentation.[13]

As this settlement illustrates, state insurance regulators have the ability to take action when an insurer is suspected of denying meritorious claims, whether because it is acting under a conflict of interest or otherwise. Moreover, because state regulators have broader exposure to the insurance business than federal courts, they are better equipped to detect when an ERISA plan fiduciary is systematically denying claims based on improper motives. Indeed, even absent consumer complaints, state regulators routinely conduct market examinations designed to detect any improprieties in claims decisions. *See, e.g.*, Me. Rev. Stat. Ann. tit. 24-A, § 221; Mo. Rev. Stat. § 374.205.1(1); N.M. Stat. § 59A-4-5. Thus, unlike federal courts, specialized state regulators have the resources, expertise, and authority to impose systemic corrective action in response to any insurer misconduct. And, to the extent that any close calls involve public policy choices, state regulators are better situated than courts to make them.

State regulatory oversight is complemented by federal regulation by the Department of Labor, which possesses a full range of enforcement mechanisms to regulate ERISA plan fiduciaries, including

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13 *See* UnumProvident Announces Settlement of Multistate Market Conduct Examination, *at* http://www.unum.com/newsroom/news/corporate/111804_Settlement.pdf.

the authority to intervene in plan proceedings on a participant's behalf, to initiate administrative enforcement actions, and to file suit against fiduciaries that have breached their obligations to plan participants. *See* 29 U.S.C. §§ 1132(a)(2), 1132(a)(5); *see also* Dep't of Labor, ERISA Enforcement, *at* http://www.dol.gov/ebsa/erisa_enforcement.html. The threat of federal regulatory action further deters plan fiduciaries from making claims determinations based on their own financial interests.

In light of the extensive state and federal regulation of insurers that serve as ERISA plan fiduciaries, it is both contrary to one of ERISA's primary goals and simply unnecessary for courts to weigh the mere fact that a company both evaluates and pays claims on judicial review to provide adequate protection for participants. Ordinary abuse-of-discretion review—together with state and federal enforcement measures—provide highly effective means of identifying, and remedying, biased decision-making by claim fiduciaries that are also insurance companies.[14]

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The resolution of this case under ERISA's conflict-of-interest principles is straightforward. The terms of the Sears Long Term Disability Plan expressly contemplate that MetLife will both evaluate and pay claims, and respondent has not come forward with any evidence indicating that MetLife's

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[14] Moreover, as illustrated by the circuits' divergent approaches, "weighing" a conflict of interest in the application of an abuse-of-discretion standard poses serious problems of judicial administration and makes it difficult for parties to predict the outcome of litigation challenging an administrator's decision.

termination of her benefits was based on financial considerations, rather than on its dispassionate evaluation of her medical record. Under the express provisions of ERISA, and the traditional trust-law principles that underpin the statute, the Sixth Circuit therefore erred when it relied on the mere potentiality of conflict to alter the abuse-of-discretion standard intended by the Plan. That benefit determination should have been reviewed for an abuse of discretion without regard to the existence of a potential conflict of interest.

II. If The Fact That A Company Both Evaluates And Pays Claims, Without More, Must Be Weighed On Judicial Review, It Should Be Only One Factor Considered In Determining Whether There Was An Abuse Of Discretion.

The lower courts have adopted three principal standards for reviewing benefit determinations by fiduciaries acting under an actual conflict of interest: abuse-of-discretion review that weighs the conflict of interest as one relevant factor (*see, e.g.*, *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006) (en banc) (disclaiming "sliding scale" label); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (5th Cir. 1999)); a burden-shifting approach that requires the fiduciary to establish that its decision was reasonable (*Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004)); and *de novo* review (*Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 91 (2d Cir. 2000)). Application of either the burden-shifting or *de novo* standard of review is inconsistent with this Court's decision in *Firestone*, ERISA's trust-law underpinnings, and the objectives that animate the statute. If

a fiduciary is deemed to operate under an actual conflict of interest solely because it separately provides the funding mechanism for the benefits at issue (or is found to be operating under any other category of actual conflict), that conflict should merely be weighed as one factor in determining whether the fiduciary abused its discretion. In the absence of evidence that the claim administrator's decision was infected by self-dealing, however, such a conflict should be given only *de minimis* weight.

Although the Sixth Circuit purported to apply the abuse-of-discretion standard, its wholesale reevaluation of Glenn's medical file indicates that it actually undertook a *de novo* review of the evidence. Thus, even if the fact that MetLife was both deciding and paying claims should be weighed on judicial review, the decision below should be reversed because the court of appeals gave that conflict undue weight and applied the wrong standard of review.

A. Abuse-Of-Discretion Review Is Compelled By *Firestone*, Trust Law, And ERISA's Statutory Objectives.

1. In *Firestone*, this Court held that, under ERISA, a "deferential standard of review [is] appropriate when a [fiduciary] exercises discretionary powers." 489 U.S. at 111; *see also LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. _ (2008) (Roberts, C.J., concurring) (slip op. at 3) ("this Court has held that ERISA plans may grant administrators and fiduciaries discretion in determining benefit eligibility and the meaning of plan terms, decisions that courts may review only for an abuse of discretion"). In contrast, if the plan does *not* afford the fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan, a benefit deter-

mination is reviewed *de novo*. *Firestone*, 489 U.S. at 115; *see, e.g.*, *Mullaney v. Aetna U.S. Healthcare*, 103 F. Supp. 2d 486, 490 (D.R.I. 2000) (applying *de novo* review).

The *Firestone* Court also considered the appropriate standard for reviewing discretionary benefit determinations by conflicted plan fiduciaries. Although the lower court in *Firestone* had concluded that the fact that the same entity both evaluates and pays claims requires *de novo* review, this Court declined to "rest [its] decision on the concern for impartiality that guided the Court of Appeals." 489 U.S. at 115. The Court expressly noted that any "concern for impartial decisionmaking" would not "foreclose[ ] parties from agreeing upon a narrower standard" than *de novo*. *Id.* Because there was no delegation of discretionary authority and *de novo* review applied, the Court did not decide whether the particular fact pattern before it *was* a "conflict" that should affect the standard of review. The Court instead stated, "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d) (second alteration in original). Later decisions confirm that *Firestone* requires abuse-of-discretion review of decisions by conflicted fiduciaries. *See Rush Prudential*, 536 U.S. at 384 n.15 ("In *Firestone Tire* itself, we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised.").

Firestone therefore authoritatively forecloses application of a *de novo* standard of review or a burden-shifting approach to evaluate a decision by a con-

flicted plan fiduciary, and instead suggests that courts may weigh a conflict of interest as one factor in determining whether there was an abuse of discretion. There is no reason to revisit that conclusion here. *See* Br. in Opp. to Pet. for Cert. 24 (endorsing *Firestone*'s approach); U.S. Cert. Br. 16 (same).

2. *Firestone*'s rejection of the burden-shifting and *de novo* approaches is confirmed by traditional trust-law principles and ERISA's statutory objectives.

As *Firestone* recognized, trust law provides for abuse-of-discretion review where a trustee is given a discretionary power, even when the trustee operates under an *actual* conflict of interest. In applying this abuse-of-discretion standard, "the burden of proof remains on the party challenging the fiduciary's conduct as there is no presumption against the fiduciary despite the divided loyalty." *In re Estate of Halas*, 568 N.E.2d 170, 178 (Ill. App. Ct. 1991).[15] The *de novo* and burden-shifting approaches are therefore also squarely at odds with ERISA's trust-law underpinnings.

Thus, if this Court concludes that the deferential standard of review intended by the plan must be modified to take into account the type of potential, theoretical conflict at issue here, it should nonetheless reaffirm that abuse-of-discretion review remains the rule when the plan gives fiduciaries discretionary power, and should direct, as *Firestone* suggested,

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15 *See also Gregory*, 590 S.W.2d at 670-71 (even in the presence of an actual conflict of interest, it must be "presumed that a trustee has acted in good faith and the burden of proof rests upon those who question his actions and seek to establish a breach of trust"); *Wolfe*, 651 N.E.2d at 466; *Rosencrans*, 95 A.2d at 913; *Bank of Nev. v. Speirs*, 603 P.2d 1074, 1077 (Nev. 1979).

that any such conflict simply be considered as part of the required deferential review. If any modification of the abuse-of-discretion standard is appropriate at all, this one, as the United States has recognized, "best balances" ERISA's employee protections "with the statutory authorization for fiduciaries to serve in dual roles . . . and for employers generally to set up plans as they see fit." U.S. Cert. Br. 17.

Although the majority of courts of appeals is therefore correct to reject the *de novo* and burden-shifting approaches, there is wide variation among those courts in the application of the weighing approach that they apply instead. There are especially large variations regarding the amount of weight (if any) courts give to the fact that a company both evaluates and pays claims. For that reason, if the Court concludes that some weight should be given to the fact that a company evaluates and pays claims, it should clarify that—in the absence of a showing that the determination was infected by self-dealing so as to bias the decision-maker against the claim—courts should give *de minimis* weight to the fact that a company both evaluates and pays claims. Giving this arrangement anything more than the most minimal weight on judicial review would be inconsistent with the fact that Congress expressly contemplated—and endorsed—such arrangements. Moreover, the existence of significant procedural protections for plan participants under federal and state law also effectively prevents companies from acting upon any theoretical conflict of interest they may have under such circumstances.

B. The Court Of Appeals Did Not Apply An Abuse-Of-Discretion Standard Of Review.

Although the Sixth Circuit professed to apply an abuse-of-discretion standard of review, in reality, it undertook a *de novo* review of MetLife's benefit determination in which it reweighed the evidence in Glenn's file without according any deference to MetLife's decision and faulted MetLife for failing to discuss each piece of evidence in that file, including the SSA's benefit determination. A faithful application of the abuse-of-discretion standard of review—even one that treats as a "conflict" the mere fact that MetLife both evaluated and paid claims—establishes that MetLife's decision to terminate Glenn's benefits was reasonable and should have been upheld.

1. The Court Of Appeals Gave Undue Weight To The Fact That MetLife Both Evaluated And Paid Claims.

As an initial matter, the fact that MetLife both evaluates and funds benefits warrants *de minimis* weight, if any, in review of its termination of Glenn's benefits. Glenn was provided with a number of procedural protections—including an opportunity to submit evidence of cardiac insufficiency that would support her treating physician's attempt to retract his pre-denial statements that Glenn could perform full-time sedentary work, a right to administrative review of the determination, and review by a nurse consultant and two independent medical examiners—that limited any opportunity MetLife had to act in a biased manner. These procedural protections are even more rigorous than those required by the Department of Labor regulations, which do not require the physician consulted by a plan during ad-

ministrative review to be independent of the plan. 29 C.F.R. § 2560.503-1(h)(3)(v); *cf. Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998) (holding that less deferential review is triggered where a fiduciary denies a claim "without seeking any independent medical review").

Moreover, there was no evidence that MetLife's benefit determination was in fact infected by self-dealing. There were no procedural irregularities in MetLife's disposition of Glenn's claim, which was thoroughly reviewed on three different occasions by MetLife's claims administrators. Nor was the evidence so inconsistent with MetLife's determination that the only possible inference is that MetLife acted to further some improper motive.

On the contrary, the record demonstrates that MetLife's conclusion that Glenn was not disabled from performing any job was completely reasonable. The medical records establish that, as a result of "appropriate medical management and biventricular pacing, [Glenn] has achieved a relatively stable cardiac status." J.A. 39a. Glenn's ejection fraction—a critical indicator of her heart condition—had improved from 22% in March 2000 to 40-50% after medical treatment (*id.* at 72a, 74a), the same rate she had throughout the 1990s (*id.* at 41a), when she was able to perform her demanding job at Sears, which required walking and standing for 60% to 100% of the workday (*id.* at 115a). Most significantly, Dr. Patel, her treating physician, twice indicated in physical capacity evaluations submitted to MetLife that, in an eight-hour workday, Glenn could sit eight hours, stand four hours, and walk two hours. *Id.* at 54a, 58a. Dr. Patel was specifically asked whether Glenn was able to work full-time at a sedentary physical exertion level occupation, and he

checked "yes." *Id.* at 58a. Dr. Moyer, an independent physician, concurred with Dr. Patel's conclusion after reviewing Glenn's records. C.A. App. 170. Based on these evaluations and Glenn's vocational background, a Certified Rehabilitation Coordinator found that there were alternative sedentary occupations available for which Glenn had transferable skills, namely account information clerk, attendance clerk, and classified ad clerk. J.A. 100a-03a. In light of this evidence, MetLife concluded on July 13, 2002, that Glenn was not disabled from performing *any* gainful occupation. *Id.* at 14a-15a.

In the administrative appeal that ensued, MetLife reasonably determined that Dr. Patel's revised conclusion that Glenn could not even perform sedentary work—issued nine days after MetLife made the decision to terminate Glenn's benefits—did not outweigh the contrary medical evidence. Although that evidence established that Glenn could not work in the high stress position of Sears sales manager, which required extensive lifting, standing, and walking, there were five medical assessments in the record—two from Dr. Patel and one each from Drs. Moyer, Pujara, and Snider—that concluded that Glenn could perform sedentary work. Dr. Pujara, for example, concluded that the available medical records indicated that Glenn was "capable of sedentary activity as per the U.S. Department of Labor Guidelines." J.A. 39a. And Dr. Snider, an independent examiner who testified during the SSA hearing and who was found to be credible by the ALJ, also concluded that Glenn was able to perform sedentary activity as long as it involved a "low stress work environment" and light exertion. Pet. App. 45a.

It was therefore well within the bounds of MetLife's discretion to credit this evidence over Dr.

Patel's conveniently-timed change of heart, particularly in the absence of any change in the underlying medical records. Indeed, this Court has acknowledged that claim fiduciaries need only "credit a claimant's *reliable* evidence." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003) (emphasis added); *see also Barnhart*, 179 F.3d at 589 (the fact that a fiduciary "reached a decision contrary to [plaintiff's] medical evaluators, when it based this decision on substantial evidence in the record, reports of outside medical reviewers, and conflicting evidence in [plaintiff's] own submissions to the record," did not render the decision arbitrary or capricious).[16]

2. MetLife Was Not Required To Address The SSA Decision In Its Written Benefit Determination.

Relying on its decision in *Darland v. Fortis Benefits Insurance Co.*, 317 F.3d 516 (6th Cir. 2003), *overruled in part by Nord*, 538 U.S. 822, the court of ap-

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[16] MetLife's skepticism about the medical opinion offered by Dr. Patel after MetLife had determined that Glenn was no longer eligible to receive disability benefits is consistent with this Court's recognition that "a treating physician, in a close case, may favor a finding of 'disabled.'" *Nord*, 538 U.S. at 832. Indeed, according to one survey, 64.3% of treating physicians believe that it is necessary to manipulate insurance plan rules to obtain insurance payments, including exaggerating the severity of the patient's condition. *See* Matthew K. Wynia, *Physician Manipulation of Reimbursement Rules for Patients*, 283 J. Am. Med. Ass'n 1858 (2000); *see also* Victor G. Freeman, *Lying for Patients—Physician Deception of Third-Party Payers*, 159 Archives of Internal Med. 2263 (1999) (reporting a survey in which 57.7% of treating physicians self-reported that they would give a false diagnosis to obtain insurance payments for a patient).

peals also faulted MetLife for "act[ing] . . . in unacknowledged conflict with the determination of disability by the Social Security Administration." Pet. App. 25a. In so doing, it directly contradicted this Court's decision in *Black & Decker Disability Plan v. Nord* and misconstrued the record before the SSA.

a. In *Nord*, this Court refused to extend the so-called "treating physician" rule, developed in the social security context, to ERISA. The Court held that, unlike social security ALJs, ERISA claims administrators are not required to give "special weight to the opinions of a claimant's physician" or to provide a written explanation for disagreeing with the opinion expressed by a claimant's physician. 538 U.S. at 834. The Court acknowledged that "ERISA and the Secretary of Labor's regulations under the Act require 'full and fair' assessment of claims and clear communication to the claimant of the 'specific reasons' for benefit denials" (*id.* at 825), but concluded that nothing in this statutory or regulatory framework "command[s] plan administrators to credit the opinions of treating physicians over other evidence" (*id.*), or "impose[s] on plan administrators a discrete burden of explanation" in writing when they "credit reliable evidence that conflicts" with a treating physician's conclusion. *Id.* at 834. The Court emphasized that the "treating physician" rule is inapplicable in the ERISA context in both its "procedural" form—which "requires a hearing officer to explain why she rejected the opinions of a treating physician"—and its "substantive" form—which "requires that 'more weight' be given to the medical opinions of a treating physician." *Id.* at 834 n.4.

The Sixth Circuit's requirement that MetLife provide a written refutation of an SSA disability determination is flatly inconsistent with *Nord*'s conclu-

sion that courts may not impose a discrete "burden of explanation" on plan administrators. Although Department of Labor regulations prohibit plan administrators from refusing to consider evidence presented by a participant, *Nord* makes clear that they are not required to discuss such evidence or mention it in writing because ERISA's objectives are best served by "preserv[ing] the greatest flexibility possible for . . . operating claims processing systems." 538 U.S. at 833 (internal quotation marks omitted; ellipsis in original). Moreover, because a social security ALJ—unlike an ERISA claim administrator—is required to give special weight to a treating physician's opinion (20 C.F.R. § 404.1527(d)(2)), the court of appeals' written refutation requirement gives a treating physician's opinion, even if credible, a degree of weight that this Court explicitly rejected in *Nord*.

b. Contrary to the Sixth Circuit's contention that MetLife acted in "conflict" with the SSA decision (Pet. App. 25a), the SSA proceedings actually corroborate MetLife's benefit determination.

The ALJ who presided over the SSA proceedings did not conclude that Glenn was physically unable to perform any sedentary occupation. Indeed, the ALJ credited the opinion of Dr. Snider, who testified that Glenn "could sit throughout the day with normal breaks," could "stand and walk for three to four hours total during the workday," and was "limited to [a] low stress work environment." Pet. App. 44a-45a.

The SSA found Glenn to be disabled because she lacked vocational skills to perform the type of jobs available to someone with her physical limitations. The transferable skills assessment before the SSA found that Glenn had no skills that were "transferable" to sedentary jobs within her physical capacity.

Pet. App. 47a. Under SSA regulations, the Commissioner had the burden of disproving this vocational assessment, but he introduced no contrary evidence. *Id.* at 46a; *see also Bowen v. Yuckert*, 482 U.S. 137, 146 n.5 (1987) ("the Secretary bears the burden of proof at step five, which determines whether the claimant is able to perform work available in the national economy."). It was solely because the Commissioner wholly defaulted on his obligation to meet this burden that the SSA found Glenn to be totally disabled.[17]

The burden of proof for Glenn's ERISA claim, however, was different than that for her SSA claim because, under the terms of the Plan, it was Glenn who bore the burden of establishing that she could not perform sedentary work. J.A. 161a. She failed to meet that burden because the vocational TSA—which was not before the ALJ—established that there were several jobs in her geographic area for which she was qualified and physically fit. Glenn was under no such burden in the SSA proceedings, where the Commissioner was required to affirmatively establish that she could perform sedentary work. In light of these divergent burdens of proof and factual records, it was reasonable that MetLife would reach a conclusion that was different than the one reached by the SSA, but unreasonable to expect claims examiners to be able to articulate these substantive and procedural differences.

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[17] Moreover, it does not appear that the SSA had Dr. Patel's March 2002 and June 2002 assessments that Glenn had regained the capacity to do full-time sedentary work. J.A. 128a-30a; *see also Block*, 952 F.2d at 1455 (acknowledging the significance of different records considered by the SSA and ERISA claims fiduciaries).

c. The fact that MetLife encouraged Glenn to apply for social security benefits was consistent with its fiduciary obligation and does not change this analysis.

In order to reduce the employer's cost of providing benefits, the Plan provides that disability benefits will be reduced by the amount of social security and other benefits for which the participant is eligible. J.A. 166a-68a.[18] Because the terms of the Plan authorize MetLife to implement this deduction even if the participant does not actually apply for social security benefits, MetLife derives no financial advantage from encouraging a participant to apply for benefits and then requesting that the participant reimburse it for any overpayment of benefits. After it is reimbursed for the overpayment, MetLife is in no better position than it would have been had it remained silent and reduced the participant's benefits based on estimated SSDB. Indeed, it would be inconsistent with ERISA's objectives and MetLife's fiduciary obligations to penalize MetLife for administering the Plan in accordance with its terms and for encouraging participants to apply for government benefits to which they may be entitled, particularly when the Plan requires benefits be reduced by estimated SSDB if beneficiaries fail to apply for them. *See also supra* pg. 6-7 (detailing other ways the SSDB award directly benefited Glenn).

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[18] This is a common provision of long-term disability plans for the additional reason that it is not in the public interest for disabled individuals to receive more income than they did while in the workforce.

3. MetLife's Evaluation Of The Medical Evidence Was Reasonable.

Finally, the court of appeals criticized MetLife for "reject[ing] Dr. Patel's more detailed reports" of Glenn's health while crediting the "check-off forms" in which he indicated that Glenn was capable of performing sedentary work. Pet. App. 20a. The court of appeals' criticism is both legally and factually flawed.

Determining whether Dr. Patel's physical capacity evaluations were more credible than his other evaluations of Glenn's health required resolution of a disputed issue of fact. Under abuse-of-discretion review, "The fact that the . . . court might reasonably have concluded that a different [determination] was appropriate is insufficient to justify reversal of" a fiduciary's benefit determination. *Gall*, 128 S. Ct. at 597; *see also* Br. for the United States as *Amicus Curiae* at 13, *Nord* (No. 02-469) ("A plan that confers discretion on the administrator to determine whether a claimant is disabled necessarily leaves to the administrator the discretion to resolve factual disputes, such as the nature and extent of the claimant's medical condition and physical limitations."). A court must therefore defer to a fiduciary's reasonable resolution of a disputed issue of fact, even if the court would have resolved the dispute in a different manner.

This is not what the court of appeals did here. It improperly substituted its own evaluation of the medical evidence for MetLife's. Indeed, MetLife's decision to reject Dr. Patel's revised conclusion regarding Glenn's work capacity is well-supported by the extensive record evidence demonstrating that Glenn could perform a sedentary job, including evidence

from Dr. Patel himself. J.A. 54a, 58a. Three other independent physicians who reviewed Glenn's medical records concluded that Glenn was capable of performing sedentary activity in a "low stress work environment." Pet. App. 45a; J.A. 39a; C.A. App. 170. These medical opinions flatly contradicted Dr. Patel's revised conclusion—reached only after MetLife had decided to terminate Glenn's benefits—that she could not work in a low-stress setting, and they are consistent with the objective medical evidence, which demonstrates that, with drug treatments and biventricular pacing, Glenn's ejection fraction had greatly improved and her heart function was normal or within the "lower limits of normal." J.A. 74a.

The court of appeals also faulted MetLife for offering "no explanation for its resolution of the conflict [between Dr. Patel's revised conclusion and the conclusions of other physicians] or, for that matter, whether it was given any consideration at all." Pet. App. 20a. By detailing the medical information in the file that undermined the reliability of Dr. Patel's change of heart, however, MetLife did just that. J.A. 24a-26a. Moreover, as this Court concluded in *Nord*, a fiduciary's conclusion must be upheld if supported by reliable evidence (such as the two physical capacity evaluations completed by Dr. Patel before the denial and the independent medical assessments of Drs. Pujura and Snider), regardless of whether the fiduciary provides a written basis for rejecting conflicting evidence.[19]

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[19] Moreover, although MetLife did not explicitly question his credibility, Dr. Patel made several misleading statements in his reassessment of Glenn's condition. In his February 12, 2003 letter, Dr. Patel stated that Glenn's ICD device had "no rol[e]" in "improving her cardiac function" and was only meant to pro-

Finally, the fact that Dr. Patel's physical capacity evaluations of March and June 2002 were completed on "check-off forms" does not diminish their significance. In fact, the physical capacity evaluations deserve more weight than Dr. Patel's generalized reports on Glenn's condition because they are the only pre-termination documents in which Dr. Patel was specifically asked to evaluate Glenn's ability to perform full-time work. *Cf. D. Ginsberg & Sons, Inc. v. Popkin*, 285 U.S. 204, 208 (1932) ("Specific terms prevail over the general."). Those forms made clear to Dr. Patel that MetLife sought his opinion for the specific purpose of evaluating Glenn's ability to return to work. *See* J.A. 57a ("We are evaluating [Glenn's] ability . . . to return to fulltime work within her capabilities. To complete our assessment we need your input.").[20]

[Footnote continued from previous page]

vide defibrillation if needed (J.A. 42a)—an assertion that is contradicted by Dr. Patel's earlier acknowledgment that Glenn's ICD device also included biventricular pacing (*id.* at 71a, 75a), which is capable of significantly improving cardiac function. Indeed, Dr. Pujara had previously stated that, as a result of "appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status," and predicted that Glenn's "work capacity should improve" even further with biventricular pacing. *Id.* at 39a. Similarly, in his July 22, 2002 letter, Dr. Patel stated that Glenn "has tried to return to work in the past with exacerbation of her symptoms." *Id.* at 44a. MetLife learned, however, that Glenn had not in fact tried to return to work at any time after April 2000. *Id.* at 58a.

[20] The manner in which Dr. Patel completed the physical capacity evaluations also demonstrates that he did not check the boxes thoughtlessly. For example, Dr. Patel was instructed, in the event he answered "no" to the question whether the patient could work in a sedentary occupation, to list or describe any

In light of the substantial record evidence contradicting Dr. Patel's July 2002 and February 2003 assessments, MetLife's decision to terminate Glenn's benefits was reasonable and did not remotely constitute an abuse of discretion.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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physical barriers preventing Glenn from returning to work full-time. Dr. Patel responded "NA." J.A. 58a.

APPENDIX

Title 29 U.S.C. § 1002 provides, in relevant part:

§ 1002. Definitions

* * *

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation,

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise,

which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate,

is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

* * *

(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

* * *

Title 29 U.S.C. § 1106 provides, in relevant part:

§ 1106. Prohibited transactions

(a) Transactions between plan and party in interest. Except as provided in section 408:

(1) A fiduciary with respect to a plan shall not cause the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect—

(A) sale or exchange, or leasing, of any property between the plan and a party in interest;

(B) lending of money or other extension of credit between the plan and a party in interest;

(C) furnishing of goods, services, or facilities between the plan and a party in interest;

(D) transfer to, or use by or for the benefit of, a party in interest, of any assets of the plan; or

(E) acquisition, on behalf of the plan, of any employer security or employer real property in violation of section 407(a).

(2) No fiduciary who has authority or discretion to control or manage the assets of a plan shall permit the plan to hold any employer security or employer real property if he knows or should know that holding such security or real property violates section 407(a).

(b) Transactions between plan and fiduciary. A fiduciary with respect to a plan shall not—

(1) deal with the assets of the plan in his own interest or for his own account,

(2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a

party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or

(3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

(c) Transfer of real or personal property to plan by party in interest. A transfer of real or personal property by a party in interest to a plan shall be treated as a sale or exchange if the property is subject to a mortgage or similar lien which the plan assumes or if it is subject to a mortgage or similar lien which a party-in-interest placed on the property within the 10-year period ending on the date of the transfer.

Title 29 U.S.C. § 1108 provides, in relevant part:

§ 1108. Exemptions from prohibited transactions

* * *

(c) Fiduciary benefits and compensation not prohibited by 29 U.S.C. § 1106. Nothing in section 406 shall be construed to prohibit any fiduciary from—

(1) receiving any benefit to which he may be entitled as a participant or beneficiary in the plan, so long as the benefit is computed and paid on a basis which is consistent with the terms of the plan as applied to all other participants and beneficiaries;

(2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full-time pay from an

employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred; or

(3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

* * *

Title 29 C.F.R. § 2560.503-1 provides, in relevant part:

§ 2560.503-1 Claims procedure.

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

* * *

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such informa-

tion was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to

whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

* * *

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notifi-

cation of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule,

guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

* * *

No. 06-923

IN THE

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

– v. –

WANDA GLENN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF FOR RESPONDENT

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QUESTIONS PRESENTED

Petitioner MetLife is a dual-role ERISA plan fiduciary, which means that it both decides whether beneficiaries are eligible for benefits and pays any benefits it grants out of its own pocket. The Court of Appeals found MetLife's denial of an employee's disability claim arbitrary and capricious in multiple respects. The questions presented are:

1. Was the Court of Appeals correct in concluding that MetLife's dual-role status is a conflict of interest that a court must consider in reviewing MetLife's benefit denial?

2. If a dual-role insurer is deemed to be operating under a conflict of interest, how should that conflict be taken into account in judicial review of a discretionary benefit decision?

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STATEMENT OF THE CASE

Petitioner Wanda Glenn maintained an impeccable work record at Sears, Roebuck, and Company ("Sears") for 14 years, when a potentially fatal heart disease cut her career short. P.A. 2a, 46a.[1] Ms. Glenn, now 55, turned to MetLife to pay the benefits she had been promised under Sears's long-term disability plan, an employee welfare benefit plan governed by ERISA. P.A. 3a.

The Court of Appeals found MetLife's denial arbitrary and capricious in multiple respects, noting that MetLife systematically and inexplicably ignored critical evidence, reversed positions, and rejected the consistent opinion of an examining cardiologist in favor of consultants who reviewed a cold paper record. P.A. 10a–25a. In the course of its opinion, the Court of Appeals took note of the fact that MetLife is a dual-role insurer, which means that it both (1) decides whether to pay benefits and (2) pays any benefits it grants out of its own pocket. P.A. 10a. In so doing, the Court of Appeals was following this Court's direction in *Firestone Tire & Rubber v. Bruch*, that such a dual-role "conflict *must* be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. 101, 115 (1989) (quoting RESTATEMENT

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[1] The Petition is cited as "Pet." and the Appendix to the Petition is cited as "P.A." Petitioners' merits brief is cited as "Pet'r," and the Joint Appendix as "J.A." The Administrative Record in the District Court is cited as "A.R." Amicus briefs are cited as "_____ Br.," according to the abbreviation or shortened name of the lead amicus.

(SECOND) OF TRUSTS § 187, cmt. d (1959) ("SECOND RESTATEMENT") (emphasis added)).

MetLife insists that the ruling must be vacated because the Court of Appeals *must not* even consider that dual-role conflict of interest in reviewing the benefit denial. MetLife's position is inconsistent with this Court's precedent, trust law, ERISA's purposes, and common sense.

Ms. Glenn Is Disabled by a Severe Heart Condition

The disease that ended Ms. Glenn's career has plagued her for more than 25 years. It began with hypertension, in the early 1980s. P.A. 4a. Then, in 1989, Ms. Glenn suffered a near-death experience called "sudden cardiac death." *Id.* Doctors implanted a defibrillator in Ms. Glenn's chest to keep her alive, but her condition deteriorated over time. *Id.*

Doctors diagnosed Ms. Glenn with left ventricular dysfunction, *id.*, and then eventually with severe dilated cardiomyopathy, a disease that interferes with the heart's ability to pump blood, P.A. 3a. Ms. Glenn suffered prolonged chest tightness, shortness of breath, and "increasing fatigue" throughout the day. P.A. 4a; J.A. 82.

By the spring of 2000, Ms. Glenn's treating cardiologist, Dr. Rajendra Patel, concluded that Ms. Glenn had to leave Sears to preserve her health. P.A. 4a–5a. The "physical as well as psychologic stress" from her job as a manager, he concluded, was literally deteriorating her heart. J.A. 82. In April 2000, Dr. Patel opined, "From my standpoint, this patient cannot return to any kind of job that would require any significant physical or

psychological stress." J.A. 88. A cardiovascular disease specialist at Ohio State University confirmed the diagnosis. P.A. 43a. Acceding to doctors' orders, Ms. Glenn took medical leave. P.A. 4a–5a.

MetLife Helps Persuade the Social Security Administration Ms. Glenn Is Disabled

Ms. Glenn submitted a long-term disability claim to MetLife. P.A. 3a. MetLife was contractually bound to pay disability benefits for the first two years if Ms. Glenn could not "completely and continuously ... perform each of the material duties of [her] regular job" as a sales manager. *Id.* (alteration in original). MetLife concluded that Ms. Glenn was "totally disabled" within the meaning of the plan. *Id.*

Even before issuing the first disability check, MetLife set out to ensure that it could reduce some of its eventual outlay to Ms. Glenn. P.A. 11a; J.A. 145–47. As MetLife informed Ms. Glenn in October 2000, it had a right to offset any benefits it owed her by the full amount of any Social Security disability benefits she might recover. J.A. 147. Ms. Glenn had already filed an application with the Social Security Administration ("SSA") on her own initiative months earlier. A.R. 214. But MetLife was not content to let that pending SSA application run its course. Instead, MetLife directed Ms. Glenn to "contact Kennedy & Associates," a law firm specializing in Social Security benefits, "in the

near future," to ensure a favorable disability ruling. J.A. 146. Ms. Glenn acceded. A.R. 219.[2]

The Medical Leave Helps Ms. Glenn Stabilize but Not Enough to Return to Work

Ms. Glenn's medical leave had the stabilizing effect her doctors had hoped. P.A. 5a. Dr. Patel observed "some ... improvement" in Ms. Glenn's heart condition "*from the reduction of stress and strain of work.*" J.A. 84 (emphasis added); P.A. 5a. But Dr. Patel consistently concluded she was too sick to return to work. She "still gets fatigued out and short of breath," he opined, "particularly if she is under any kind of significant psychologic stress." J.A. 62.

Thus, at the four-month mark, Dr. Patel informed MetLife that Ms. Glenn would "*Never*" "be able to resume work" "*For Any Occupation.*" J.A. 110 (Aug. 2000) (emphasis added). He repeated that conclusion, in haec verba, at the six-month mark, J.A. 81 (Nov. 2000), after 15 months, J.A. 99 (June 2001), and after 20 months, J.A. 70 (Dec. 2001), each time adding she was "totally disabled." Neither Dr. Patel's notes nor his ample correspondence with her primary care physician ever

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[2] MetLife asserts that it "derive[d] no financial advantage" from assisting Ms. Glenn, because the plan authorizes MetLife to deduct SSA benefits "*if* the participant *does not actually apply* for social security benefits." Pet'r 52 (emphasis added). But Ms. Glenn *had* applied for benefits on her own. *See* A.R. 214. *But cf.* P.A. 3a (mistakenly suggesting otherwise). So the plan prohibited MetLife from reducing her benefits, unless the SSA awarded benefits. J.A. 168–69; A.R. 16–17. MetLife intervened because it stood to gain, not because it was on a charity mission.

wavered from this opinion. *See, e.g.*, J.A. 37–99, 105–11.

Ms. Glenn's Condition Remains Static, Despite an Aberrational "X" on a Form

The only hint to the contrary in Ms. Glenn's entire claim file was a lone "X" on an insurance form. The form, dated March 13, 2002, bears Dr. Patel's signature. J.A. 58. The form, which is different from all the others Dr. Patel had routinely signed, posed several stock questions. One of those questions was whether the insured is "able to work in a sedentary physical exertion level occupation." *Id.* An "X" is scrawled next to a pre-printed "yes." *Id.* The X-marked question did not specify that it was asking about returning to *full-time* work. *Id.* In the same form, Dr. Patel also reported on the number of hours a day Ms. Glenn could sit (8 hours), stand (4 hours), or walk (2 hours). *Id.* Had Dr. Patel scrutinized the form's boilerplate preamble, he might have discerned that MetLife would use the form to assess "her ability to return to full-time work," J.A. 57, but that is not what these questions asked. Nor did Dr. Patel explicitly state anywhere else on the form that—contrary to all his previous "Never" entries—Ms. Glenn had made a miraculous recovery and was ready to return to full-time work. J.A. 58.

To the contrary, on a "Physical Capacities Evaluation" form faxed along with the March form, J.A. 59, Dr. Patel stated, "*More* [Left Ventricular] Dysfunction Noted on Recent Echo," J.A. 61 (emphasis added), indicating that Ms. Glenn's condition was worsening. And at Ms. Glenn's most recent physical examination, a month earlier, Dr. Patel reported that she "continues to have exer-

tional shortness of breath on *any kind of emotional excitement* or any kind of significant physical exertion," and that her "[e]jection fraction," which measures the efficiency of the heart's pumping, "*again has gone back down* to 35–40%." J.A. 50–51 (emphasis added); *see* Pet'r 4 ("below 35% is considered poor").

As the Court of Appeals concluded, that lone X mark was "so inconsistent with other medical evidence and detailed reports supplied by Dr. Patel over a period of three years that it can best be described as aberrational." P.A. 16a. Within three months, Dr. Patel confirmed as much. On June 12, on another Physical Capacities Evaluation form, Dr. Patel reiterated his earlier view about Ms. Glenn's ability to sit, stand, and walk, J.A. 54, but he added the caution: "No emotional stress/no heavy exertion." J.A. 56. Contrary to MetLife's assertion, nowhere on this second form did "Dr. Patel ... conclude[] that [Ms.] Glenn could perform sedentary work." Pet'r 47. The form did not even ask the question (as the March 13 form had). J.A. 52–56. But just six days later, on June 18, Dr. Patel found it necessary to address the question anyway: He reported that she "was back in [his] office earlier than expected," due to "shortness of breath." J.A. 46. He examined her and declared—with the same certitude he had been expressing all along—"I do not believe she will handle any kind of stress well at her work and she would be better off being on disability." J.A. 47.

Contrary to MetLife's contentions, Pet'r 13, 45, 58, Dr. Patel took this position a month before MetLife terminated Ms. Glenn's benefits. J.A. 14.

MetLife Successfully Pursues SSA Disability Benefits

Meanwhile, on March 13, 2002—coincidentally, the very day of the fateful X mark—MetLife's preferred lawyers appeared before an administrative law judge ("ALJ") to argue that Ms. Glenn was too disabled to work *at any job*. P.A. 41a; J.A. 131–44. They insisted that "conservative and aggressive treatments have failed to provide long-term, consistent relief or improvement that would allow [Ms. Glenn] to return to a sustained level of work activity, *even at a sedentary exertional level*, without exacerbation of her cardiac dysfunction." J.A. 144 (emphasis added). In other words, they argued that *any* job would worsen Ms. Glenn's heart condition; she would be unsuitable "in even an unskilled work environment." J.A. 143. They supported this position with the reams of medical evidence MetLife had amassed as well as other medical information from Ms. Glenn's doctors. J.A. 131–44.

The ALJ agreed and ordered retroactive and prospective benefits on June 15, 2002. J.A. 13, 120; P.A. 41a–49a. He agreed that (as the relevant statute requires) Ms. Glenn could not "engage in *any* ... *kind* of substantial gainful work which exists in the national economy, regardless of [where] such work exists." 42 U.S.C. § 423(d)(2)(A) (emphasis added); P.A. 13a n.1, 47a.

MetLife allocated a fraction of the award for the lawyers and pocketed the rest. P.A. 11a; J.A. 118–19, 123.

MetLife Immediately Decides Ms. Glenn Is Not Disabled, After All

Less than a month after securing the ALJ's decision, on July 13, 2002, MetLife informed Ms. Glenn that it was now taking the opposite position against her: It concluded she *could* perform some *other* sedentary job. J.A. 14. That conclusion disqualified Ms. Glenn from benefits after the initial two-year disability period. After that mark, the plan—just like the SSA—required proof that she was "unable to perform the duties of *any* gainful work or service for which [she is] reasonably qualified" (as opposed to being unable to return to her previous job). P.A. 3a (alteration in original).

Why the about-face? MetLife blamed mainly the aberrational X. MetLife had enlisted an outside physician to review Ms. Glenn's cold file. A.R. 39. Seizing on the March report, the consultant attributed to *Dr. Patel* the conclusion that Ms. Glenn "could perform sedentary work." *Id.*; P.A. 30a. In terminating Ms. Glenn's benefits, MetLife said nothing of the SSA decision it helped obtain. J.A. 15. It was as if the SSA proceeding had never happened.

MetLife Persists in Denial, Ignoring Key Medical Information and the SSA Ruling

Ms. Glenn sought reconsideration. P.A. 31a. In support of the request, she submitted a letter from Dr. Patel, this one dated July 22, 2002, reaffirming his view by exclaiming: "I do not believe Wanda should be forced to return to any kind of *even sedentary work*." J.A. 44 (emphasis added). "[A]ny kind of psychologic stress at work," he emphasized,

"causes significant problems with her cardiovascular condition." P.A. 6a; J.A. 44 (emphasis added).

MetLife was unmoved. It denied reconsideration in August 2002. J.A. 29–33. In the denial letter, MetLife asserted—inexplicably—that "[t]here is no supportive medical documentation of the exacerbation of your cardiac condition and symptomology, due to subjective complaints of work-related stress." J.A. 31. MetLife did not mention Dr. Patel's consistent assertion that Ms. Glenn should "Never" return to work of any sort, or his July 22 letter insisting that Ms. Glenn was "completely disabled" and unable "to return to any kind of even sedentary work." J.A. 44, 45. So it felt no need to explain why these medical assessments did not qualify as "supportive medical documentation."

MetLife did, however, home in on other snippets of Dr. Patel's reports. It cited his November 2001 report that Ms. Glenn was "clinically stable" now that she was on leave, and, again, the aberrational X on the March 2002 form. J.A. 30. MetLife also fixated on a few words in Dr. Patel's June 18 report showing "an ejection fraction of 35 to 40%" (which is actually borderline "poor," Pet'r 4), but ignored his statement in the same report that Ms. Glenn should not return to work. J.A. 31; *see* J.A. 47. Once again, MetLife made no effort to reconcile its conclusion with the SSA ruling it helped produce.

Ms. Glenn appealed the denial through MetLife's internal review procedure. P.A. 31a. In support of the appeal, Dr. Patel issued yet another, more urgent letter, this one dated February 2003. J.A. 41–43. He acknowledged the aberrational X

mark on the March 2002 form, seeming to indicate "that the patient was fit for sedentary work." J.A. 42. But he insisted—consistent with everything he had said before and since—that "based on her clinical condition and her symptomology, *there was never a time* where I felt that this patient would be able to return to *full-time employment*." *Id.* (emphasis added). Directly rebutting MetLife's surmise that his opinion was based merely on "subjective complaints of work-related stress," J.A. 31, Dr. Patel protested: "Ms. Glenn does not have any emotional condition that causes her cardiac problem. She has a cardiac problem that is exacerbated by any kind of stress." *Id.*; J.A. 42. In sum, he definitively stated: "My position is that she should be considered completely disabled." J.A. 42.

In response, MetLife hired another outside consultant. P.A. 8a. He, too, merely reviewed the paper files. J.A. 37–40. As the Court of Appeals observed, the second consultant's "prognosis was, at best, ambiguous." P.A. 8a. On the one hand, he agreed that Ms. Glenn could not engage in "exertional physical activity," and that "[t]he actual impact of any form of real or perceived emotional stress [on Ms. Glenn's heart condition] is difficult to gauge in an individual patient." J.A. 39. On the other hand, he concluded that "the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis." *Id.*

This new consultant found support for his conclusion in Dr. Patel's evaluation from June 12, 2002. J.A. 38, 39. Nowhere in his evaluation did he refer to Dr. Patel's more explicit, and emphatic, conclusions from June 18, 2002, July 2002, and February 2003, insisting that Ms. Glenn was "com-

pletely disabled" and not able to work at "any kind" of job. P.A. 6a, 7a; J.A. 42. This omission led the Court of Appeals to conclude that he "[was] apparently not provided [by MetLife] with full information from Dr. Patel." P.A. 25a.

Despite the consultant's equivocation, MetLife issued a final denial of disability benefits in May 2003. J.A. 23–26; *see* P.A. 8a. Echoing its second consultant, MetLife relied upon the form Dr. Patel filled out on June 12, 2002. J.A. 24. This time, MetLife acknowledged Dr. Patel's February 2003 assertion that Ms. Glenn was "completely disabled," but did not explain why it was rejecting this emphatic position. J.A. 25. Instead, MetLife simply concluded, again, that the "documentation currently in the file does not support a disability that would prevent Ms. Glenn from performing any occupation." J.A. 25–26. MetLife completely ignored Dr. Patel's explicit finding of disability from June 18 and July 2002, his history of saying that she would "Never" be able to return to work, and the SSA decision.

The Court of Appeals Finds MetLife's Denial Arbitrary and Capricious

Ms. Glenn filed suit in federal court under ERISA for the benefits owed to her. *See* 29 U.S.C. § 1132(a)(1)(B); P.A. 8a–9a. The District Court upheld MetLife's denial of benefits. Although it stated that it would consider MetLife's "conflict of interest ... as a factor," it applied a "deferential arbitrary and capricious standard of review." P.A. 32a–34a, 40a.

The Court of Appeals reversed. P.A. 25a–26a. The court held that MetLife's decision "can only be

described as arbitrary and capricious." P.A. 25a. It was neither "the result of a deliberative process" nor "based on substantial evidence." P.A. 2a. The court observed that MetLife's status as a dual-role insurer "creates an apparent conflict of interest," and that conflict was a "'facto[r]'" to be considered. P.A. 10a (quoting *Firestone*, 489 U.S. at 115). But the conflict was only one of a bevy of factors. The court detailed at least seven *other* flaws in MetLife's decision—describing four of them as "arbitrary" in their own right. *See infra* at 54–55 (enumerating the flaws).

On remand, the District Court found MetLife's "culpability ... high" and ordered MetLife to pay Ms. Glenn's attorneys' fees and costs. *Glenn v. MetLife*, 2007 U.S. Dist. LEXIS 3421, at *12 (S.D. Ohio Jan. 8, 2007).

SUMMARY OF ARGUMENT

I. This case presents an obvious conflict of interest. As a dual-role insurer for Sears's employee disability plan, MetLife has a financial stake in every claim for benefits that is submitted under the plan. There is nothing "potential" about MetLife's financial interest. Every time MetLife concludes that a claimant is entitled to benefits under the plan, it must reach into its own pocket and pay those benefits. Conversely, every time MetLife denies a claim, it saves the money it would have paid the employee—as it did with Ms. Glenn.

Nevertheless, MetLife insists that a court is forbidden even to consider the conflict in reviewing a benefit denial under 29 U.S.C. § 1132(a)(1)(B). Most circuits disagree with MetLife's position. That is because MetLife's position find no support

in ERISA or its underlying policies, in this Court's precedent, or in trust law.

ERISA does not prohibit a court from weighing a dual-role conflict when reviewing a benefit denial claim. All ERISA says is that it will not "*prohibit* any fiduciary" from serving a dual role. 29 U.S.C. § 1108(c)(3) (emphasis added). As this Court held in *Firestone*, Congress said nothing about how courts should scrutinize a benefit denial. Rather, ERISA imports trust law to define the standard of review. Trust law says exactly what this Court observed in *Firestone*: When a trustee operates under a conflict of interest, "that conflict *must* be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting SECOND RESTATEMENT § 187, cmt. d (emphasis added)).

In fact, trust law speaks directly to both questions presented. The most explicit statement in the most current and definitive distillation of trust law describes how courts should account for a bare conflict: Whenever bare "conflict-of-interest situations exist"—i.e., even when there is no additional evidence that the conflict affected the fiduciary's decision—"the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*." RESTATEMENT (THIRD) OF TRUSTS § 37, cmt. f(1) (2001) (emphasis added) ("THIRD RESTATEMENT").

ERISA's goals support the result dictated by trust law. The statutory goal that dominated the Court's opinion in *Firestone* was "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." 489 U.S. at 113 (citations

and internal quotation marks omitted). As in *Firestone*, this concern supports careful scrutiny. *Firestone* held that the default rule in an ERISA case is *de novo*, because otherwise employees would have less protection than they had pre-ERISA. The same is true here. If a court must give a dual-role insurer utmost deference, without any consideration of the conflict, an employee who was the victim of an improperly motivated benefit denial would be much worse off than he would have been with a contract claim under ERISA.

MetLife worries that diminished deference leads to higher costs and more frivolous litigation. This Court considered and rejected those arguments when it chose *de novo* review as ERISA's default standard. The arguments are even less compelling in a dispute over standards for a conflicted fiduciary. In any event, the rule MetLife opposes has been in place for decades in most courts, and no such dire consequences have materialized.

Equally meritless are MetLife's various other arguments against weighing the conflict. None of the supposed business realities MetLife invokes was enough to prevent UnumProvident—the largest disability insurer in the nation—from denying meritorious claims on a massive scale in pursuit of maximum profits. Similarly, arbitrary-and-capricious review will not suffice to guard against an insurer's conscious or subconscious shading of benefit decisions. And state and federal administrative agencies do not, and are not expected to, protect individual claimants. Congress prescribed complementary roles for *both* regulators and judges. While regulators provide *systematic* over-

sight, Congress gave judges the responsibility to review individual claims for benefits due—like this one—under § 1132(a)(1)(B), and to do so in a way that advances both ERISA's goal of protecting claimants' contract rights and its unwaivable requirement that plan fiduciaries act in the sole interest of beneficiaries.

II. Trust law leaves no doubt that a court must apply "especially careful scrutiny" to a benefit denial simply because there is a conflict. THIRD RESTATEMENT § 37, cmt. f(1). This is a deferential standard. Nevertheless, courts applying this standard routinely re-weigh the evidence to ascertain for themselves whether the trustee's position is outside the range of reasonableness they would expect from an unconflicted trustee. Beyond that, courts should (1) demand complete and careful explanations; (2) cast a skeptical eye on the explanations they do receive; and (3) exhibit little tolerance for analytical flaws or evidentiary gaps.

When scrutiny exposes *additional* reasons to suspect that the conflict may have affected the insurer's decision, deference should diminish accordingly—all the way to *de novo* review when the suggestion of improper motive is strong.

The burden of persuasion need not shift to the insurer. But the burden of production should shift to the insurer, if the insurer wishes to argue (as MetLife does here) that it structures its business practices in a way that shields claimants from any conflict.

Finally, this Court should affirm, because the Court of Appeals left no doubt that it would reject MetLife's benefit determination under any stan-

dard of review. While the Court of Appeals considered the conflict as a "factor," it did not purport to diminish the deference it was giving MetLife. Moreover, the court's conclusion that MetLife's decision was arbitrary and capricious was based on seven additional factors—four of which the court described as "arbitrary' in their own right. In light of the Court of Appeals' analysis, a remand would be wasteful.

ARGUMENT

I. A DUAL-ROLE INSURER OPERATES UNDER A CONFLICT OF INTEREST THAT A COURT SHOULD CONSIDER IN REVIEWING BENEFIT DENIALS.

When a lawyer has a financial stake in an opposing party, he has a conflict of interest. *See* Model R. Prof. Conduct 1.7(a) (2004). When a judge owns stock in a party before her, she has a conflict of interest. *See* 28 U.S.C. § 455(b)(4). When an umpire bets on the outcome of a game he is refereeing, he has a conflict of interest. *See* Major League Baseball Rule 21(d).

MetLife is equally conflicted when it decides whether a beneficiary is entitled to benefits. If MetLife answers "yes," then it is the one who has to pay; the beneficiary's gain is MetLife's loss. MetLife "is exercising discretion over a situation for which it incurs 'direct, immediate expense as a result of benefit determinations favorable to [p]lan participants.'" *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990) (quoting *de Nobel v. Vitro Corp.*, 885 F.2d 1180, 1191 (4th Cir. 1989) (alteration in original)). That is the classic definition of an "economic conflict of

interest by [a] fiduciary," under trust law—and common parlance. *Id.*; *see infra* at 23–27. As much as MetLife tries to minimize the conflict, it never comes out and says, "The financial arrangement is not a conflict of interest."

Nor could it. Newspapers, regulators, and judges have fully documented the unfortunate reality that dual-role insurers, succumbing to the conflict, have improperly denied benefits to boost profits—sometimes on a massive scale. The most notorious offender that has been exposed is UnumProvident—the country's dominant disability insurer. *See generally* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315 (2007) (documenting the scandal). It had "a company-wide practice of denying claims based on UnumProvident's current profits," *Bennett v. Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 925, 933 (E.D. Tenn. 2004), yielding "a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics," *Radford Trust v. First Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 226, 247 & n.20 (D. Mass. 2004) (collecting citations to numerous previous cases), *rev'd in part on other grounds*, 491 F.3d 21 (1st Cir. 2007). The profit motive infected benefit decisions in subtle—and not so subtle—ways:

> Claims managers and handlers are given a quota of how many claims need to be ... denied, in a given period for the company to remain at a certain level of profitability. Medical advisors ... are offered bonuses at a

> level of 25% base pay determined, in part, on company earnings.... Claims handlers, ... supervisor[s], and even other doctors employed by UnumProvident pressured [medical personnel] to ... to deny claims.

Bennett, 321 F. Supp. 2d at 933–34. As MetLife acknowledges, regulators concluded that the conflict of interest could have tainted as many as 200,000 claim denials. Pet'r 37.

Unum is not alone in sacrificing beneficiaries' claims on the altar of profits. As the California Insurance Commissioner has observed, "[t]his is not just a UnumProvident problem; it's an insurance industry one." *See, e.g.*, Peter G. Gosselin, *The New Deal: The Safety Net She Believed In Was Pulled Away When She Fell*, L.A. Times, Aug. 21, 2005, at A1. The National Association of Insurance Commissioners agrees. *See generally* NAIC Br. As Professor Langbein documents, "[c]ases of abusive benefit denials involving other disability insurers abound." Langbein, 101 NW. U. L. REV. at 1321–22 & n.41 (collecting cases). In one notable example, the Eighth Circuit recounted how Aetna engaged in some of the same unscrupulous practices as Unum, "[a]pparently to limit claim payments." *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997). "The danger pervades the ERISA-plan world that a self-interested plan decisionmaker will take advantage of its license under [*Firestone*] to line its own pockets by denying meritorious claims.... Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect." Langbein, 101 NW. U. L. REV. at 1321.

The conflict of interest does not mean that every benefit decision Unum or Aetna—or MetLife—makes is wrong. It does not even mean that the dual-role insurer consciously shades every decision with self-interest. But it does mean that there is always a risk that "subtler operators" are occasionally indulging their own financial interests at the expense of claimants, especially on closer claims, *id.*, and that a conflicted fiduciary, like any other conflicted decisionmaker, "may favor, consciously or unconsciously, its interests over the interests of the ... beneficiaries." *Brown*, 898 F.2d at 1565; *see* GEORGE BOGERT ET AL., THE LAW OF TRUSTS & TRUSTEES § 543 (rev. 2d ed. 1993) ("BOGERT ON TRUSTS").

So the question in this case is not whether the dual-role insurer operates under a conflict of interest. Of course, it does. The question, as MetLife poses it, is whether this is the *sort* of "'conflict of interest' that must be weighed in a judicial review of the administrator's benefit determination." Pet'r i. MetLife's position is that courts reviewing the decisions of dual-role insurers are legally required to *completely ignore* this conflict of interest in assessing how much to defer to an insurer's decision to deny benefits in an ERISA case. *See* Pet'r 21–29. Most circuits to address the question disagree with MetLife, *see* U.S. Cert. Br. 7–8 (documenting 7-3 split), as does the Government, *see generally* U.S. Br. The majority rule is consistent with this Court's precedent, with trust law, and with the policies underlying ERISA. MetLife's arguments for rejecting the majority rule are unpersuasive.

A. As This Court Has Held, Congress Did Not Prescribe How to Review the Decisions of a Dual-Role Insurer, but Trust Law Provides the Answer.

1. Everyone agrees the most explicit statement Congress made about dual-role fiduciaries is this: ERISA should not be construed "to *prohibit* any fiduciary from ... serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest." 29 U.S.C. § 1108(c)(3) (emphasis added). As MetLife acknowledges, this provision "*authorizes*" the dual role. All that means is that the conflict is *not illegal*. Pet'r 21, 22. Congress did not, however, say anything about how much courts should defer to an insurer operating under such a conflict.

In fact, in *Firestone*, this Court held that ERISA says nothing at all about standards of review for benefit denials. There, this Court adopted *de novo* review as the default standard in ERISA cases. 489 U.S. at 115. That case, too, involved a fiduciary that both determined what benefits were due and paid those benefits out of its own pocket. *Id.* at 105. The central question in the case was "the appropriate standard of review in actions under § 1132(a)(1)(B)"—actions, like this one, to recover benefits. *Id.* at 108.

As this Court acknowledged, "most federal courts ha[d] reviewed the denial of benefits by ERISA fiduciaries and administrators under the arbitrary and capricious standard," but "the arbitrary and capricious standard had been softened in cases where fiduciaries and administrators had some bias or adverse interest." *Id.* at 107. In that very case, the court of appeals had held that a dual-

role fiduciary is entitled to *no* deference, on account of the conflict. *Id.* at 107–08. This holding was the central battleground in the case—at least among the parties.

The Court concluded that "the wholesale importation of the arbitrary and capricious standard into ERISA is unwarranted." *Id.* at 109 (emphasis omitted). In so ruling, this Court set forth the principles that control here. It began, as noted above, with the observation that "ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations." *Id.* It then described how courts should fill the void: "In determining the appropriate standard of review for actions under § 1132(a)(1)(B), we are guided by principles of trust law." *Id.* at 111.

This Court discerned three black-letter rules from trust law. Rule 1 is the default ERISA rule, where the plan does not say that the administrator's "eligibility determinations are to be given deference": In that context, "settled principles of trust law ... point to *de novo* review." *Id.* at 111–12.

The other two rules govern the situation where the plan does say that the fiduciary's benefit decisions are discretionary. Rule 2, for an *unconflicted* trustee, is that "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers" under the terms of the plan. *Id.* at 111 (citing SECOND RESTATEMENT § 187).

Rule 3 is the one relevant here, for it relates to *conflicted* fiduciaries: "Of course, if a benefit plan gives discretion to an administrator or fiduciary

who is operating under a conflict of interest, *that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'*" *Id.* at 115 (quoting SECOND RESTATEMENT § 187, cmt. d (emphasis added)).

2. This last passage reciting Rule 3 has been a touchstone in every circuit that has grappled with the question presented here. Yet, MetLife scarcely mentions it. MetLife dismisses the passage asserting that "the Court did not purport to determine which categories of conflicts of interest should be taken into account on judicial review." Pet'r 26. The only natural reading of the passage is that the rule applies to *any* conflict of interest. But even if one might imagine exceptions, one fact is certain: At the forefront of the Court's mind when it articulated Rule 3 was the sort of conflict that was at the heart of that very case—a dual-role fiduciary.

Despite this Court's unmistakable direction, MetLife insists that "[i]t defies logic to suggest that[] ... Congress would have expressly permitted the same entity to evaluate and pay claims if it believed that vesting both responsibilities in a single body would create a conflict of interest detrimental to plan participants." Pet'r 22. No one is suggesting that a dual-role conflict is *necessarily* "detrimental to plan participants," but only that this conflict of interest, like any conflict, *could* be detrimental to *some* plan participants *if not properly monitored*. Far from "def[ying] logic," that is exactly what trust law prescribes, as we demonstrate in the next section.

Contrary to MetLife's assertion, *Pegram v. Herdrich*, 530 U.S. 211 (2000), does not retreat from the rule this Court articulated in *Firestone*.

And it certainly does not, as MetLife claims, set out the diametrically opposite general rule that a "fiduciary's ... financial interest in a benefit determination does not, standing alone, constitute a conflict of interest that should affect the standard of review." Pet'r 22. This Court emphasized that it "ha[d] no occasion to discuss" the standard of review that applies to a dual-role beneficiary like MetLife. *Pegram*, 530 U.S. at 229 n.9. The Court held only that when an HMO physician makes a treatment decision that implicates eligibility, the physician is not engaged in a fiduciary act under ERISA. *Id.* at 231. As this Court later emphasized, a "benefit determination under ERISA ... is generally a fiduciary act," *Aetna Health Inc. v. Davila*, 542 U.S. 200, 218 (2004)—it certainly is here—so *Pegram* is a narrow exception applicable only to "a treating physician or such a physician's employer," *id.* at 221.

Outside that limited context, the rule is as *Firestone* declared, that "[o]f course ... a conflict of interest must be weighed as a 'facto[r].'" 489 U.S. at 115 (quoting SECOND RESTATEMENT § 187, cmt. d). Referring to that very sentence, MetLife inveighs, "*Firestone* ... authoritatively forecloses" any contrary view. Pet'r 42. "There is no reason to revisit that conclusion here." Pet'r 43. So stipulated.

B. This Court Correctly Concluded That, Under Trust Law, a Fiduciary's Authorized Conflict of Interest Must Be Weighed as a Factor in Reviewing the Fiduciary's Decision.

1. This Court was correct about trust law. Generally, trust law prohibits a trustee from oper-

ating under a conflict of interest at all. BOGERT ON TRUSTS § 543. But trust law authorizes the settlor who creates a trust to appoint a trustee with a financial conflict, if that is what the settlor wishes. *See, e.g., id.*; AUSTIN SCOTT & WILLIAM FRATCHER, THE LAW OF TRUSTS § 107.1 (4th ed. 2001) ("SCOTT ON TRUSTS").

Just because a settlor is allowed to appoint a conflicted trustee, however, does not mean that the courts must ignore the conflict in reviewing the trustee's actions. The law has long been that, in the interest of protecting beneficiaries, the court must weigh that conflict as a factor in reviewing the trustee's actions. The Third Restatement of Trusts reports the rule as follows:

> [T]here will inevitably be some *conflicts of interest that are approved* ... , implicitly at least, ... by the settlor .... In these circumstances there is, on the one hand, some inference of a preference for or confidence in the trustee-beneficiary but, on the other hand, a general recognition that a trustee-beneficiary's conduct is to be *closely scrutinized* for abuse, including abuse by less than appropriate regard for the duty of impartiality.

THIRD RESTATEMENT § 79, cmt. b(1) (emphasis added).

The passage this Court cited from the Second Restatement—comment d to § 187—articulates the same rule. By way of context, comment d is appended to the general principle that: "Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not

subject to control by the court, except to prevent an abuse by the trustee of his discretion." *Id.* § 187. Comment d, titled "Factors in determining whether there is an abuse of discretion," enumerates several "circumstances" that "may be relevant" to that determination. One of them is "the existence or nonexistence of *an interest* in the trustee *conflicting* with that of the beneficiaries." *Id.* § 187, cmt. d (emphasis added); *see* SCOTT ON TRUSTS § 170.23A (same).

Both the Second and the Third Restatements illustrate this authorized-conflict exception with classic trust law scenarios:

> A bequeaths all of his property to B, his son, in trust to pay the income and so much of the principal as in his discretion shall be necessary for the support and comfort of C, A's widow, and on C's death to hold the property or what remains thereof free of trust. The court will not remove B as trustee or refuse to confirm his appointment as trustee because of his conflicting interest. Such conflicting interest is, however, a *factor to be considered* by the court in determining later whether in administering the trust B is guilty of an abuse of discretion in failing to pay C sufficient [funds] for her support and comfort.

SECOND RESTATEMENT § 107, cmt. f, illus. 1 (emphasis added); *see also* THIRD RESTATEMENT § 50, cmt. b, illus. 1 (similar illustration).

In this classic scenario, the trustee operates under the same sort of dual-role financial conflict of interest as MetLife: The son is both trustee and

beneficiary—a "trustee-beneficiary," as the Third Restatement puts it. Every penny the son spends for the "support and comfort" of his father's widow, diminishes the remainder he enjoys upon her death, just as every penny MetLife spends in paying a claim diminishes MetLife's bottom line. This conflict of interest would ordinarily disqualify the son from serving as trustee. But the trustee may serve, because the settlor, aware of the conflict, has authorized the appointment, just as MetLife may serve because the employer has done the same. An employer is allowed to make that choice because ERISA expressly authorized it to do so, just as the settlor is allowed to make that choice because trust law expressly authorizes him to do so. The son's authorized dual-role conflict is so analogous to MetLife's that a leading authority on trusts treats them as equivalent. BOGERT ON TRUSTS § 255 n.54.

Not only is this sort of dual-role conflict a "factor to be considered," but the Restatements clarify that this factor modifies the standard of review for a conflicted trustee: "[W]hen a beneficiary serves as a trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*." THIRD RESTATEMENT § 37, cmt. f(1) (emphasis added); *id.* § 50, cmt. b, illus. 1 ("his acts are to be carefully scrutinized for abuse"); *id.* § 79, cmt. b(1) ("closely scrutinized for abuse"); SECOND RESTATEMENT § 107, cmt. f ("sub-

ject to careful scrutiny"). Trust law cases applying this rule are legion.[3]

Thus, MetLife is wrong when it protests that "it cannot be the case" that the law can allow an employer to "authorize" a conflict, but nevertheless "change[] the standard of review" when the employer does. Pet'r 21. That *is* the case, at least under trust law.

2. MetLife declares that "trust-law principles ... confirm that, without more, the fact that the same entity both evaluates and pays claims does not create a conflict of interest that must be weighed on judicial review." Pet'r 23. The only way to make that statement true is to attack the Restatement of Trusts with an Exacto knife and copious amounts of Wite-Out—and then turn those editing tools on scores of trust law cases.

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[3] *See, e.g.*, *White Mountain Apache Tribe v. United States*, 249 F.3d 1364, 1379 (Fed. Cir. 2001) ("The court must be particularly careful in scrutinizing ... [a]ctions of [a conflicted] trustee ...."), *aff'd*, 537 U.S. 465 (2003); *In re Peabody's Will*, 96 N.Y.S.2d 556, 561 (Sup. Ct. 1950) (when trustee operates under an authorized conflict, "his conduct in administering the trust will be more closely scrutinized"), *aff'd*, 98 N.Y.S.2d 614 (App. Div. 1950); *In re Heller*, 849 N.E.2d 262, 265–66 (N.Y. 2006) ("scrutinized by the courts with special care"); *Mesler v. Holly*, 318 So. 2d 530, 533 (Fla. App. 1975) (conflicted trustee's "discretion ... becomes particularly vulnerable to a challenge by" other beneficiaries); *In re Estate of McCart*, 847 P.2d 184, 185–87 (Col. Ct. App. 1992) (applying close scrutiny to conclude that trustee-beneficiary abused discretion); *In re Buchar's Estate*, 74 A. 237, 238 (Pa. 1909) (same); *Garvey v. Garvey*, 22 N.E. 889, 890 (Mass. 1889) (same).

The trust law authorities quoted above—including the one this Court quoted in *Firestone*—simply cannot be reconciled with MetLife's oft-repeated central theme that a dual-role conflict "cannot be weighed ... unless the [beneficiary] makes a showing that the fiduciary in fact acted on the basis of its own financial interests when carrying out its fiduciary responsibilities." *Id.*; *see* Pet'r 25, 33.

As is evident from the Restatement illustrations quoted above, the rule of heightened scrutiny revolves around "*the mere fact* that the trustee named by the settlor is one of the beneficiaries of the trust." SECOND RESTATEMENT § 107, cmt. f (emphasis added); *id.* § 107, cmt. f, illus. 1; THIRD RESTATEMENT § 37, cmt. f(1) (more scrutiny "when ... conflict-of-interest situations *exist*" (emphasis added)). In fact, when a court concludes that a conflict of interest actually has (as MetLife puts it) "infected the trustee's determination," Pet'r 26, the consequence is not just diminished deference, but *no* deference, *see, e.g.*, *Pollok v. Phillips*, 411 S.E.2d 242, 244–45 (W. Va. 1991); *In re Estate of Manahan*, 125 N.W.2d 135, 138 (Iowa 1963).

In support of its contrary view, MetLife pieces together various unrelated trust principles into the legal equivalent of a skid-row shanty. *See generally* Profs. Br.

First, MetLife cites numerous cases that stand only for the principle—not disputed here—that a court will not *remove* a trustee for a conflict of interest that the settlor has authorized. *See* Pet'r 24 n.5, 25 n.6 (citing *Estate of Freuhauf v. Comm'r of Internal Revenue*, 427 F.2d 80, 86 (6th Cir. 1970); *In re Pincus' Estate*, 105 A.2d 82, 86–87 (Pa.

1954); *In re Estate of Gilliland*, 140 Cal. Rptr. 795, 802 (Ct. App. 1977)).

Second, MetLife repeatedly invokes the general rule that "[f]iduciaries should ... be presumed to faithfully discharge their obligations in the absence of an appropriate showing ... indicating that the fiduciary's decision was actually based on an improper motive." Pet'r 33 (citing SECOND RESTATEMENT § 187, cmt. g); *see also* Pet'r 24 (quoting *Shelton v. King*, 229 U.S. 90, 94–95 (1913)). MetLife cites a famous case, involving an *unconflicted* trustee, and a Restatement passage confirming that this is "ordinarily" the rule—for *unconflicted* fiduciaries. The passage goes on to reiterate the point that the mere "fact that the trustee has an interest conflicting with that of the beneficiary is to be considered" when assessing "improper motive." SECOND RESTATEMENT § 187, cmt. g.

Third, at every turn, MetLife mischaracterizes a dual-role conflict as "a *potential* conflict," as distinguished from "an *actual* conflict." Pet'r 26; *see, e.g.*, Pet'r 25, 40. MetLife's unstated premise is that an actual conflict is one that can be proven to have affected the fiduciary's behavior, whereas a potential conflict is one that cannot. Any such notion is foreign to trust law (and any other rational body of law governing conflicts). Under trust law, an actual conflict is merely "*an interest* in the trustee conflicting with that of the beneficiaries." SECOND RESTATEMENT § 187, cmt. d (emphasis added). In contrast, a potential conflict is where the fiduciary does not *currently* have an adverse interest, but the adverse interest *might* later materialize based upon contingencies that may or may

not come to pass. *See, e.g.*, SCOTT ON TRUSTS § 170.23A. As is evident from the Restatements, treatises, and trust cases quoted above, a dual-role conflict is an actual conflict, because "the administrator has an interest (e.g., in profit or a better bottom line) that is adverse to the interests of beneficiaries seeking payment." *Post v. Hartford Ins. Co.*, 501 F.3d 154, 163 (3d Cir. 2007). Labels aside, there is no question that the very existence of the dual-role status—by whatever name—is a factor that must be considered under trust law.

Finally, MetLife invokes the inapposite trust principle that a settlor may choose to authorize a trustee to engage in *specified transactions* that would otherwise be condemned as self-dealing. Pet'r 23–24. As MetLife points out, this means that "[b]y the terms of the trust the trustee may be permitted," for example, "to sell trust property to himself individually." SECOND RESTATEMENT § 170, cmt. t (quoted at Pet'r 24); *see* Pet'r 24 n.5 (citing numerous such cases involving specific transactions). In those circumstances, the trustee has waived the duty of loyalty, and the fiduciary, by definition, is not acting solely in the beneficiaries' interests.

MetLife does not assert that ERISA authorizes dual-role insurers to engage in self-dealing. And for good reason: Regardless of what the "settlor" (i.e., employer) might consent to, the statute requires a fiduciary always to "discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and for the *exclusive purpose* of providing benefits to participants and their beneficiaries." 29 U.S.C. § 1104(a)(1)(A)(i) (emphasis added); *see, e.g.*, *Pe-*

gram, 530 U.S. at 235. So these self-dealing cases are inapplicable. But even if they were applicable, the courts still scrutinize authorized self-dealing transactions. *See* Profs. Br. §§ II.A–B; *Del. ex rel. Gebelein v. Belin*, 456 So. 2d 1237, 1239–41 (Fla. 1984); *In re Estate of Halas*, 568 N.E.2d 170, 177–79 (Ill. App. Ct. 1991).

C. ERISA's Goals Support Consideration of Dual-Role Conflicts on Judicial Review.

1. This Court had ERISA's policies firmly in mind when it opined in *Firestone* that a "conflict must be weighed" on judicial review of a benefit denial. 489 U.S. at 115. The Court invoked these goals in support of its holding that *de novo* review is the default standard for judicial review of benefit denials. The statutory goal that dominated the Court's opinion was that "ERISA was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans,' and 'to protect contractually defined benefits.'" *Id.* at 113 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983), and *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)); *see generally* Profs. Br. § III.

A deferential default standard, the Court held, would undermine this goal, because it "would afford *less* protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Firestone*, 489 U.S. at 114 (emphasis added). As the Court understood, in the pre-ERISA world, employees had the right to bring state-law contract claims for the denial of promised benefits, and those claims would be subject to *de novo* review. *Id.* at 113–14. Congress eliminated their state-law claims. But it is inconceivable that

Congress intended to replace those claims with a regime in which the fiduciary could decide the employees' contract rights and be almost entirely immunized from judicial scrutiny.

The same criticism applies with greater force here. Before ERISA, when an employee sued an insurance company for benefits, the court would not only have subjected the denial to *de novo* review, but it would have resolved any contractual ambiguity *against* the insurer. 2 G. COUCH, R. ANDERSON, & M. RHODES, COUCH ON INS. 2D § 15:83, at 399 n.4 (rev. ed. 1984) (citing cases from the District of Columbia and 47 states, with no contrary authority). These protections shielded the employee from any possibility that the insurer's profit motive—consciously or subconsciously—affected its decision. It seems just as inconceivable that, in eliminating the contract action against an insurer who succumbs to a conflict, Congress intended *also* to eliminate the reviewing court's ability to detect the injustice.

2. MetLife acknowledges that "dual policies underl[ie] ERISA." Pet'r 26. But the interest that dominated this Court's opinion in *Firestone* is absent from MetLife's brief—except for a seven-word cameo, vaguely noting that one goal is "to protect the interests of plan participants." *Id.* Instead, MetLife lavishes attention only on the countervailing goal, "to facilitate the formation of employee benefit plans by minimizing the administrative and financial burdens on plan administrators." *Id.* (internal quotation marks omitted). Even if dwelling on half the balance were appropriate, MetLife's analysis of that half is unpersuasive, and has largely been rejected by the Court already.

First, MetLife extols the virtues of "[t]he consolidation of claims administration and funding responsibilities within a single company." Pet'r 26. But no one is advocating a rule (as MetLife put it in its petition) "to discourage employers from appointing claims administrators that also fund the plan." Pet. 11. The rule allowing courts to consider a dual-role conflict as a factor in reviewing benefit denials does not discourage dual-role fiduciaries any more than a rule allowing courts to scrutinize the decisions of a dual-role trustee discourages fathers from making their sons both trustees and beneficiaries. In either context, the rule simply allows courts to play their customary role of protecting beneficiaries from the possibility that the trustee's conflict might hurt them.

In any event, MetLife's emphasis on costs and administrative burdens would be an argument (as it was in *Firestone*) for applying the most deferential standard of review to all fiduciaries, in all circumstances. This Court rejected the argument, opting instead for a default rule that gives *no* deference. *See Firestone*, 489 U.S. at 115. Those same goals cannot now support a rule of utmost deference in more specific circumstances, particularly not in circumstances where trust law demands careful scrutiny. *Cf. Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385 (2002) ("Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly.").

Next, MetLife predicts that anything less than full deference "will inevitably encourage participants with dubious claims to file suit," and will

force fiduciaries to *grant* meritless claims. Pet'r 27 & n.8. This Court rejected this argument, too, in *Firestone*, when it chose a standard that, by the same theory, would encourage even more dubious claims and unwarranted grants. *See* 489 U.S. at 115. As this Court held, "the threat of increased litigation is not sufficient to outweigh the reasons for a *de novo* standard that we have already explained." *Id.*

Apart from this Court's authoritative response, there is also a practical response to MetLife's parade of horribles: For the past 20 years, most courts have been weighing the conflicts of dual-role insurers on review of benefit denials. There is no evidence that employers have shunned insurance companies, that meritless litigation has swamped the courts, or that fiduciaries are granting *too many* claims. If the horribles have lain dormant for two decades, they are not likely to rear their heads when this Court adopts the majority rule.

D. MetLife's Other Arguments for Utmost Deference Are Unpersuasive.

MetLife makes several other arguments for departing from the rules dictated by trust law and supported by ERISA's goals. Each is unpersuasive.

1. Business "realities." MetLife expounds at length on business "realities" in the insurance industry. Pet'r 29–33. But none of these supposed realities sufficiently protects beneficiaries. The leading trust law scholar in the nation has dissected and authoritatively refuted each argument. *See* Langbein, 101 NW. U. L. REV. at 1327–31; *see also* UP Br. §§ I.A–I.C. We briefly respond to each.

First, MetLife argues, in essence, "we aim to please": Insurers have "long-term business incentives to treat claimants fairly," lest they lose "dissatisfied customers." Pet'r 29–30 (internal quotation marks omitted). But this dynamic is worthless unless employees and employers police millions of claim denials. They do not and cannot. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000); Langbein, 101 NW. U. L. REV. at 1328–29.

Second, MetLife observes that "several courts have noted [that] individual claims are often quite minute when compared with" the billions in profits of "supposedly conflicted decision-makers." Pet'r 30. Here is how one such court put this drop-in-the-bucket argument: "Unum is much too large to be affected by its resolution of any one benefits claim." *Shyman v. Unum Life Ins. Co.*, 427 F.3d 452, 455 (7th Cir. 2005) (Easterbrook, J.). That was obviously wrong. MetLife is urging this Court to make the same mistake the Seventh Circuit made: to ignore the obvious point that MetLife is engaged in a high-volume business. If an airline finds it profitable to skimp with trivial cost-cutting measures—for example, by substituting pretzels for peanuts—then an insurance company processing thousands of claims can find profit in skimping on meritorious claims like Ms. Glenn's $350,000 claim.

Third, MetLife argues that not "every dollar that the insurance company pays in benefits" necessarily "comes directly out of its profits." Pet'r 30. But all MetLife actually demonstrates is that dual-role insurers can still make a profit without succumbing to the conflict. It does not deny that

cheating beneficiaries could *increase* profits even more, by suppressing costs. *See Pinto*, 214 F.3d at 388; Langbein, 101 NW. U. L. REV. at 1330–31.

Finally, in a variation on the old saw, MetLife argues that insurance companies don't deny claims, agents do. Agents, MetLife asserts, "do not have direct personal stakes in the outcome of their decisions." Pet'r 31. That is obviously false for insurers that give bonuses based on profits or that pressure adjusters to deny claims. *See supra* at 17–18; *see generally* Langbein, 101 NW. U. L. REV. 1315. Even while Unum was meting out improper denials by the thousands, courts were holding that "[n]othing in our record suggests that UNUM has even tried" to adopt incentives for employees to deny claims in the interest of maximize profits. *Perlman v. Swiss Bank Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999). As to the other insurers, MetLife does not cite any authority for the novel proposition that trust law or ERISA distinguishes a conflicted trustee from its agents.

Contrary to MetLife's analogy, *see* Pet'r 31, insurance adjusters, who resolve the financial interests of their own employers, are nothing like ALJs, who are public employees bound by "a well established set of procedural protections that stem from the Constitution and individual statutes." *Ramsey v. Hercules Inc.*, 77 F.3d 199, 205 (7th Cir. 1996); *see* Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727, 738–43 (2004). To take one obvious example, unlike claims adjusters, ALJs are required to give claimants a full and fair hearing replete with all the

trappings of an adversarial adjudicative process. *See Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000) (Posner, J.). Notably, "when the initial decision in an agency lacks the crucial procedural safeguards, the Administrative Procedure Act requires the federal courts to review both fact and law *de novo*." *Ramsey*, 77 F.3d at 205. Thus, under the administrative law paradigm, claims adjusters would get *no* deference.[4]

All four of these arguments fail at an even more fundamental level: They do not negate the conflict; at most, they might be mitigating factors. Under trust law, such arguments are relevant to assessing the severity of the conflict—and MetLife is free, in any benefit case, to present evidence of the mitigating effect. *See infra* at 49–50. But the possibility

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[4] For similar reasons, MetLife is incorrect in asserting that fiduciaries deserve utmost deference because they "have much more extensive experience reviewing the merits of such claims than do federal courts." Pet'r 28. Once, again, this Court rejected the same argument—advocating greater deference for *un*conflicted fiduciaries—in *Firestone*. 489 U.S. at 113–15. It is even less persuasive here. In any event, as the Third Circuit has pointed out, claims adjusters "are not governmental agencies who are frequently granted deferential review because of their acknowledged expertise. [Adjusters] may be laypersons appointed under the plan, sometimes without any ... training preparing them for their responsible position, often without any experience in or understanding of the complex problems arising under ERISA." *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991); *see also Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 (3d Cir. 1987), *aff'd in part, rev'd in part on other grounds*, 489 U.S. 101 (1989); *Ramsey*, 77 F.3d at 205.

that factors might mitigate the conflict does not justify ignoring the conflict entirely.

2. Adequacy of arbitrary-and-capricious review. MetLife posits that courts need not even consider the dual-role conflict, because "the faulty reasoning offered in an attempt to justify an inappropriate denial of a meritorious claim will inevitably result in a finding that the decision is arbitrary and capricious on judicial review." Pet'r 35–36. There is nothing inevitable about it. Under the arbitrary-and-capricious standard—at least as applied by the lower courts—a court will uphold the fiduciary's decision so long as there is "a *rational connection* between the facts found ... and the choice made"; a court will overturn a plan interpretation only if it "defies *all* common sense." *Dabertin v. HCR Manor Care, Inc.*, 373 F.3d 822, 828 (7th Cir. 2004) (emphasis added). It does not take the genius of a Charles Ponzi for an adjuster bent on denying a meritorious claim to satisfy this standard, especially if the claim presents a close call. If "the outcome in a close case is influenced in part by a desire to control the insurer's or plan sponsor's costs, the fiduciary's claim denial *surely will not disclose that fact.*" PETER J. WIEDENBECK, ERISA IN THE COURTS 194 (2008) (emphasis added) ("WIEDENBECK"). Savvy insurers will cherry pick and accentuate their best facts, while ignoring or diminishing their worst facts with little explanation.

MetLife does not prove otherwise merely by citing a handful of cases—out of millions of claim denials and hundreds of ERISA cases applying the most deferential standard—where the insurer's position happened to fall short of this low threshold.

See Pet'r 35 n.10. These cases prove only what Unum has already taught us: Sometimes insurers are "clumsy villain[s]." Langbein, 101 NW. U. L. REV. at 1321. Evidence that some villains get caught is hardly proof that there are no "subtler operators" who evade detection. *Id.*

Much more informative is the statistic MetLife cites about the outcome of the Unum investigation. Expert regulators concluded that some 200,000 denials were potentially tainted by conflict that either went unchallenged by claimants or uncorrected by reviewing courts. Pet'r 37. Of the denials Unum reviewed, it came to conclude that 40% were improper. *See Unum Group Swings to Profit from Quarterly Loss; Claims Reassessment 'Substantially Completed'*, BEST WIRE (Nov. 1, 2007), *available at* Lexis, News Database. Indeed, the deferential standard of review is what emboldened Unum to cheat: When there are "gray areas," one Unum executive enthused, "ERISA applicability may influence our course of action." Langbein, 101 NW. U. L. REV. at 1321 n.40 (internal quotation marks omitted).

3. Agency oversight. MetLife is correct that "it is the province of state insurance departments" and the Department of Labor "to *oversee and systematically examine* insurance practices, including claims processing." Pet'r 37 (emphasis added). Both the Department of Labor and the National Association of Insurance Commissioners insist that their oversight is no substitute for adequate scrutiny of claims in *individual cases*. *See generally* U.S. Br.; NAIC Br.

As these agencies understand, Congress prescribed complementary roles for *both* regulators

and judges. Congress expected the regulators to provide *systematic* oversight. But Congress vested judges with the equally important responsibility to review *individual claims for benefits due*—like this one—under § 1132(a)(1)(B), and to do so in a way that advances ERISA's goal "to protect contractually defined benefits." *Firestone*, 489 U.S. at 113 (internal quotation marks omitted). When Congress eliminated employees' rights to bring contract actions, Congress was not signaling that employees who have been cheated should feel sufficiently consoled by the possibility that some regulator might some day punish the insurer for a systematic abuse.

4. Contractual intent. Finally, MetLife asserts that diminishing deference for a conflicted trustee would amount to "rewrit[ing] the deferential standard that the plan settlor envisioned when it delegated discretionary authority to the claim fiduciary." Pet'r 28–29.

That may conceivably be true, but, if so, it is because this Court rejected the contract paradigm in *Firestone* when it concluded that trust law controls. 489 U.S. at 109–13; *see Firestone*, U.S. Amicus Brief § I.A (advocating contract paradigm); UP Br. § I.E. The settlor in each of the Restatement illustrations and cases discussed above may be said to have intended to grant the conflicted trustee utmost discretion—and might have explicitly done so—but *trust law* intervenes to raise the standard of scrutiny in the interest of better pro-

tecting the beneficiary.[5] Because this Court imported the trust law principles built into ERISA—including a non-waivable duty of loyalty—to fashion a standard of review, ERISA does the same.

II. A COURT REVIEWING A DUAL-ROLE INSURER'S BENEFIT DENIAL SHOULD START WITH "ESPECIALLY CAREFUL SCRUTINY" AND DIMINISH DEFERENCE AS THE CIRCUMSTANCES WARRANT.

Exactly how a dual-role conflict affects the standard of review has "bedeviled the lower courts." WIEDENBECK, at 192. One reason is that they treat it as a single question. In truth, the inquiry boils down to three questions: (A) What level of deference should a dual-role insurer's decisions enjoy in cases involving a bare conflict? (B) Does the level of deference ever diminish from that baseline, and, if so, under what circumstances? (C) Do the burdens ever shift to the insurer? We address each in turn. For this case, however, the precise contours of the standard do not matter, for the Court of Appeals would have reached the same conclusion under any standard.

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[5] When this Court stated in dicta in *Firestone* that "[n]either general principles of trust law nor a concern for impartial decisionmaking ... forecloses parties from agreeing upon a narrower standard of review," 489 U.S. at 115, it merely recognized that settlors may grant discretionary authority to trustees. *Id.* at 111–13. It did not purport to decide how much deference a conflicted trustee would enjoy.

A. Review of the Decisions of a Dual-Role Insurer Must Begin with "Especially Careful Scrutiny."

1. The most explicit statement in the most current and definitive distillation of trust law describes how courts should account for a bare conflict: Whenever bare "conflict-of-interest situations exist"—i.e., even when there is no additional evidence that the conflict affected the fiduciary's decision—"the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*." THIRD RESTATEMENT § 37, cmt. f(1) (emphasis added).

What does "especially careful scrutiny" mean? In ERISA cases, most courts of appeals, echoing trust law, have held that a conflicted "fiduciary's judgment will ... be scrutinized more closely," which means that "deference will be lessened." *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 86–87 (4th Cir. 1993). Some say they are applying "abuse of discretion review, tempered by skepticism," *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 959 (9th Cir. 2006) (en banc), while others say they will defer only "to an administrator's reasonable and carefully considered conclusions," *Post*, 501 F.3d at 164.

Lower courts, however, have been struggling with how to apply these standards. *See generally* LAS-ELC Br. § IV. Sometimes, they announce that they are considering the conflict, but then proceed with the analysis as if the conflict did not exist, much as the District Court did in this case. *Id.* Other times, they purport to apply a heightened version of arbitrary-and-capricious review, but in practice scarcely apply any scrutiny at all. *Id.*; *see,*

e.g., *Brigham v. Sun Life of Can.*, 317 F.3d 72, 81–86 (1st Cir. 2003). The lower courts need this Court's guidance not just on the name of the standard, but on how to apply it. *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004) ("Our failure to articulate clearly the requirements of a less deferential arbitrary and capricious standard has left district courts in this circuit without direction and has encouraged litigation."). Failure to do so is like admonishing a foreigner to be especially quiet at the U.S. Open, without telling him whether the frame of reference is a soccer match or a chess match.

Because the standard is stated in comparative terms, the starting point for discerning the meaning of "especially careful scrutiny" must be the standard of review for an unconflicted trustee. An unconflicted trustee's decision "will not be disturbed if *reasonable*." *Firestone*, 489 U.S. at 111 (emphasis added). That is not the same as the arbitrary-and-capricious standard courts apply to expert administrative agencies operating under stricter procedural requirements. *See* Profs. Br. § II.A; *supra* at 38-39. *Reasonableness*, in trust law, requires more than just some rational connection between a shred of evidence and the conclusion. *See, e.g.*, *Copp v. Worcester County Nat'l Bank*, 199 N.E.2d 200, 202 (Mass. 1964).

"[E]specially careful scrutiny," then, means scrutiny must be enhanced above that baseline of review for reasonableness. Because the point of enhanced scrutiny is to enable the reviewing court to satisfy itself that the conflict did not affect the outcome—whether consciously or unconsciously—courts take whatever additional steps are necessary

to achieve that goal. In some trust cases, courts accord a conflicted trustee no deference at all.[6] In most, the courts still defer, just not as much as they would to a conflict-free trustee.[7] Certain practices are readily discernible from the body of case law. *See supra* at 27 n.3 (citing cases); Profs. Br. §§ II.A–B (cataloging cases); *see also Gebelein*, 456 So. 2d at 1239–40; *Halas*, 568 N.E.2d at 175–77. First and foremost, courts applying this standard invariably re-weigh the evidence to ascertain for themselves whether the trustee's position seems out of synch with the range of reasonableness they would expect from an unconflicted trustee. Profs. Br. §§ II.A–B. Beyond that, these cases typically (1) demand complete and careful explanations; (2) cast a skeptical eye on the explanations they do receive; and (3) exhibit little tolerance for analytical flaws or evidentiary gaps. *Id.*

This trust law standard is the approach that best balances ERISA's competing interests as well. On the one hand, it preserves the discretion the plan grants to the insurer, without presuming that their decisions are wrong or tainted. On the other hand, this standard casts the court in the important, and traditional, role of protecting the beneficiary's contractual and statutory rights by ensuring that dual-role insurers act solely in the interests of plan beneficiaries, a fundamental and non-

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[6] *See, e.g., First Nat'l Bank of Beaumont v. Howard*, 229 S.W.2d 781, 785 (Tex. 1950); *Rogers v. Rogers*, 18 N.E. 636, 637–38 (N.Y. 1888); *Armington v. Meyer*, 236 A.2d 450, 456 (R.I. 1967).

[7] *See, e.g., Buchar's Estate*, 74 A. at 238; *Mesler*, 318 So. 2d at 533; *Peabody's Will*, 96 N.Y.S.2d at 561.

waivable requirement of ERISA. 29 U.S.C. § 1104(a)(1)(A). And the standard is not so deferential as to allow—and even encourage—widespread abuse, whether from a "clumsy villain" or from "subtler operators." Langbein, 101 NW. U. L. REV. at 1321.

2. One reason the lower courts have been confused is that many have misinterpreted this Court's direction, in *Firestone*, that a dual-role "conflict must be weighed as a 'facto[r] in determining *whether there is an abuse of discretion*.'" 489 U.S. at 115 (quoting SECOND RESTATEMENT § 187, cmt. d (emphasis added)). Some courts have read this statement—as MetLife does here—to mean that a court must apply an "abuse-of-discretion [*standard of*] *review* ... even when the trustee operates under an actual conflict of interest." Pet'r 43 (emphasis altered); *see Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997) ("[I]n no case does the court deviate from the abuse of discretion standard."). This reading confuses an abuse-of-discretion *standard of review* (as that term is often used in administrative law) with a *legal conclusion* that a trustee has abused his discretion (under trust law).

In trust law, the determination that a trustee has "abused his discretion" is the *legal conclusion* a court reaches—a label the court applies—upon overriding the trustee's decision. *See, e.g.*, BOGERT ON TRUSTS § 560; Profs. Br. § II.A. It is a shorthand for an act that justifies "judicial intervention on the ground of abuse." THIRD RESTATEMENT § 87, cmt. c.

That is not the same as declaring that this determination of abuse must always be made using a particular standard of review. And it is certainly

not the same as a conclusion that the decisions of *conflicted* trustees must be adjudged by the same arbitrary-and-capricious standard (borrowed from administrative law) that is routinely applied to *un*-conflicted fiduciaries. The Restatement itself draws the distinction. It explains that "[w]hat *constitutes an abuse of discretion* depends on the terms and purposes of the trust, ... as well as on applicable principles of fiduciary duty." THIRD RESTATEMENT § 87, cmt. b. One of those principles is that, when reviewing the decisions of a conflicted fiduciary, a court can find abuse of discretion upon applying "especially careful scrutiny." *See supra* at 42. Simply put, an arbitrary-and-capricious *standard of review* that applies "especially careful scrutiny" is a contradiction in terms. *See supra* at 38–39 (discussing highly deferential standard). As this Court recently observed, it is questionable "just how deferential the review can be when the judicial eye is peeled for conflict of interest." *Rush*, 536 U.S. at 384 n.15.

B. Deference to a Dual-Role Insurer Should Decline As Scrutiny Exposes Additional Reasons to Suspect That the Conflict May Have Affected the Insurer's Decision.

1. "[E]specially careful scrutiny" is the starting point for a court confronting a bare dual-role conflict. But when scrutiny exposes *additional* reasons to suspect that the conflict may have affected the insurer's decision, deference should diminish accordingly—all the way to *de novo* review when the suggestion of taint is strong. *See generally* LAS-EC Br. § V.

This pattern, too, is evident in countless trust law cases. *See supra* at 27 n.3, 44 nn. 6–7; Profs. Br. § II. Precisely because they discern that pattern in trust law, virtually every circuit agrees that, under ERISA, deference should decrease in proportion to the quantum of evidence that the conflict might have affected the outcome. *See* Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1155 (2001) (cataloguing cases). Under this approach, "courts first consider the evidence that the administrator acted from an improper motive and heighten their level of scrutiny appropriately." *Post*, 501 F.3d at 161–62. Thus, deference diminishes as the reviewing court finds further reason "to doubt [the insurer's] fiduciary neutrality," *id.* at 165—when "the process *raises* questions," *id.* at 168, or "suspicion," *id.* at 165. The greater the evidence of taint or impropriety, "'the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it.'" *Stup v. Unum Life Ins. Co. of Am.*, 390 F.3d 301, 307 (4th Cir. 2004) (quoting *Ellis*, 126 F.3d at 233).

At some point the suspicion of a taint can be sufficiently strong that the reviewing court should give no deference to the conflicted insurer's decisions and apply *de novo* review.[8] That is the rule

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[8] *See, e.g., Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74 (1st Cir. 2005) ("[T]he court may cede a diminished degree of deference—*or no deference at all*—to the administrator's determinations." (internal quotation marks omitted; emphasis added)); *Van Boxel v. Journal Co. Emp'ees Pension Trust*, 836 F.2d 1048, 1052–53

(footnote continued...)

under trust law, for the only reason a fiduciary enjoys *any* deference is that he is obligated to make decisions wholly in the interests of the beneficiary. *See, e.g.*, *Clement v. Larkey*, 863 S.W.2d 580, 581–82 (Ark. 1993); *Buchar's Estate*, 74 A. at 237. That rule translates into ERISA as well. After all, undivided loyalty is a fundamental and non-waivable *requirement* of ERISA. *See* 29 U.S.C. § 1104(a)(1)(A). When evidence leads a court to harbor serious doubts about it, it makes no sense to accord the fiduciary any deference at all.

2. In determining whether to diminish deference (and how much), courts should be free to evaluate any evidence bearing on the conflict or the fiduciary's behavior. It is impossible here to enumerate all the relevant factors, and this Court need not try. But one of the most important steps the Court can take to guide the lower courts and ensure uniformity is to adopt a basic framework and articulate, with illustrations, the *sorts* of factors that the lower courts should look out for in fixing the degree of deference.

The Third and Ninth Circuits have offered both a useful analytical structure and a helpful, non-exhaustive list of factors that reviewing courts should consider. *See Post*, 501 F.3d at 162–65; *Abatie*, 458 F.3d at 969–71. The factors fall into two basic categories—"procedural" and "structural." *Post*, 501 F.3d at 162.

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(7th Cir. 1987) (for "a serious conflict of interest, the proper deference to give their decisions may be ... zero").

The most common form of evidence that a conflicted fiduciary succumbed to the conflict is evidence about the *process*—"how the administrator treated the particular claimant." *Id.* This category includes various "irregularities" such as: "(1) reversal of position without additional medical evidence; (2) self-serving selectivity in the use and interpretation of physicians' reports; (3) disregarding staff recommendations that benefits be awarded," *id.* at 164–65 (citations omitted); (4) "provid[ing] inconsistent reasons for denial"; (5) "fail[ing] adequately to investigate a claim"; (6) "fail[ing] to credit a claimant's reliable evidence," *Abatie*, 458 F.3d at 968; and (7) denying disability after advocating disability to the SSA, without explaining the difference, *Ladd v. ITT Corp.*, 148 F.3d 753, 755–56 (7th Cir. 1998).

MetLife repeatedly describes this case as presenting the bare conflict, "without more." Pet'r i. But there *is* more—much more. The Court of Appeals found ample evidence of the sorts of procedural irregularities that have routinely raised alarm bells, including items (1), (2), (4), (5), (6), and (7), from the above list. *See infra* at 54–55. The presence of these factors would have justified diminishing deference far below the level of "careful scrutiny," and even all the way to zero, i.e., to *de novo* review (which, as we shall demonstrate, is not what the Court of Appeals did).

The structural component "focuses on the financial incentives created by the way the plan is organized," *Post*, 501 F.3d at 162, on the insurer's track record, and other factors extrinsic to the administrative record. Under this rubric, the Third Circuit has identified dual-role insurers--

particularly those that fund the benefits "on a case-by-case basis," as MetLife does—as especially undeserving of deference. *Id.* at 163. Among the other factors the courts of appeals have identified in this category are: (1) whether the administrator "use[s] an independent body to evaluate claims," *id.*; (2) "whether the insurance contract is fixed for a term of years or changes annually, ... [3] whether the fee paid by the company is modified if there are especially large outlays of capital by the insurer," *Pinto*, 214 F.3d at 392, and (4) whether the insurer has displayed "a parsimonious claims-granting history," *Abatie*, 458 F.3d at 968–69.

Notably, several of these structural factors are the very ones that MetLife and its amici recite in an effort to demonstrate that the conflict is less stark for some dual-role insurers. Pet'r 30–31; BCBS Br. at 12–19; ACLI Br. at 3–6, 13–19. Any insurer that insulates its adjusters from the dual-role conflict in these ways, or that has an impeccable record of consistent plan interpretations, should be free adduce such evidence—which would militate against further diminished deference. *See Abatie*, 458 F.3d at 969.

MetLife has adduced none of this evidence in this case, which leads to the question whether this Court (or any reviewing court) should accept MetLife's invitation to presume their existence—a question we turn to next.

C. The Burden of Proof Does Not Shift, but the Burden of Production Should.

Some courts address the dual-role conflict by shifting the burden of proof to the insurer, requiring the insurer to "negate[]" a presumption of

improper influence "by ameliorating circumstances, such as equally compelling long-term business concerns that militate against improperly denying benefits despite the dual role." *Schatz v. Mut. of Omaha Ins. Co.*, 220 F.3d 944, 947–48 (8th Cir. 2000) (internal quotation marks omitted). There is support in trust law for such an approach. *See, e.g., Clement*, 863 S.W.2d at 581–82. But so long as scrutiny is adequate, it is unnecessary to shift the burden of proof.

That said, it is appropriate to shift the burden of *production* to insurers, as to certain facts. For example, insurers are best situated to present evidence of the sort described immediately above—evidence bearing on their own safeguards. *See Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers Pension Trust for S. Cal.*, 508 U.S. 602, 626 (1993) ("It is indeed entirely sensible to burden the party more likely to have information relevant to the facts about [the issue] with the obligation to demonstrate [those] facts ...."). It is virtually costless for an insurer to introduce a stock affidavit attesting to its precautions. Dual-role insurers almost never introduce such evidence—perhaps because they have become complacent in the face of fairly toothless review by courts or, just as likely, because they do not take any such precautions.[9]

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[9] One amicus provides a perfect illustration, arguing that insurance companies "have as much incentive to provide employees with bonuses for claim processing accuracy" as those companies do for claim denials. BCBS Br. 15. The public record suggests otherwise. *See supra* at 17-18. But the point here is that MetLife—or any other insurer—is welcome to proudly present to a reviewing court evidence that it

(footnote continued...)

That is their prerogative. But when the record is silent on the subject—as it is here—the claimant should not be penalized for the evidentiary void.

D. The Judgment Should Be Affirmed, Because the Court of Appeals Would Have Reached the Same Conclusion Under Any Standard of Review.

MetLife did not seek certiorari to review whether the Court of Appeals' analysis of the evidence was "[a] faithful application of the abuse-of-discretion standard," Pet'r 45, or whether its various criticisms of MetLife's process were correct. Yet, MetLife devotes more than a quarter of its argument to urging this Court to scrutinize those fact-bound conclusions about the medical evidence, the consistency of Dr. Patel's opinions, and MetLife's about-face. Pet'r 45–56. MetLife even presents an extended legal argument on a question on which this Court pointedly *denied* certiorari. *Compare* Pet. i (second question presented) *with* Pet'r 48–52. All of this is beyond the scope of this case and this Court's customary role.

When it comes to the Court of Appeals' analysis of MetLife's denial, only one question is properly before this Court: In light of the Court of Appeals' analysis, is it necessary to remand the case to apply the standard this Court articulates?

A remand is unnecessary, because the Court of Appeals left no doubt that it would have reached

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minimizes any conflict by rewarding employees for *granting* claims.

the same result under *any* standard. That is clear both from what the court said about the conflict and from what the court said about MetLife's decision.

As to the conflict, the Court of Appeals said that MetLife's dual-role status was a "facto[r]" to be considered; the conflict was "relevant." P.A. 10a. The court mentioned the factor at the outset, *id.*, but the factor did not come up again throughout the court's lengthy analysis of the various flaws that infected MetLife's denial, P.A. 10a–24a. The court did not mention it again until its conclusion, in half a sentence, intermixed with a grab bag of seven other bases for finding an abuse of discretion. P.A. 25a.

The court contrasted its approach with the District Court's approach (which was simply to quote *Firestone*'s sentence about weighing the conflict, *see* P.A. 34a, without any further "consideration"). P.A. 10a. At no point in it is opinion, however, did the Court of Appeals purport to accord MetLife less deference than it would give to an unconflicted fiduciary. To the contrary, the court said it was applying "the 'arbitrary and capricious' standard," P.A. 9a, a "highly deferential standard," P.A. 24a. As if to punctuate the point, the court defined that standard as MetLife does. *Compare* P.A. 9a, 24a–25a *with* Pet'r 34. In short, the most that can be said is that the court considered the conflict as a factor, but gave the factor "*de minimis* weight," just as MetLife proposes. Pet'r 44.

In keeping with the standard it articulated, the court then held that MetLife's "decision ... can only be described as arbitrary and capricious." P.A. 25a. It was not "the result of a deliberative process."

P.A. 2a; *see* P.A. 25a. Nor was it "based on substantial evidence." P.A. 2a. Of the seven *other* bases the court gave in support of that conclusion, noted below, the court described four as "arbitrary" in and of themselves. P.A. 25a.

Thus, contrary to MetLife's assertion, the court did not apply *de novo* review—in name or in effect. Pet'r 45. The court did not, for example, delve into the intricacies of Ms. Glenn's "ejection fraction," her "defibrillator evaluation," her "capture and sensing thresholds," and so forth—as *de novo* review would demand. J.A. 31. As MetLife acknowledges, even on the most deferential version of abuse-of-discretion review, a court may focus on "procedural irregularities in MetLife's disposition of Glenn's claim." Pet'r 46. That is exactly what the court did. It found the following irregularities:

(1) MetLife failed to offer *any reason* "to discount or disagree with" the SSA's determination, P.A. 15a (internal quotation marks omitted), after "reap[ing] a financial benefit" from taking the opposite litigation position, not a month earlier, P.A. 11a. That about-face, alone, "can be considered *arbitrary and capricious.*" P.A. 13a (emphasis added).

(2) "Even more perplexing" was MetLife's "failure *to give any weight* to Dr. Patel's letters ... , in which he clearly stated that he did not believe Glenn was capable of returning to work, sedentary or otherwise." P.A. 15a (emphasis added); *see* P.A. 18a. By that, the court meant that MetLife "did not indicate whether or not it had considered" these letters, and offered no "reason

for rejecting" them. P.A. 19a.

(3) MetLife "seems to have ... almost randomly selected" snippets of information "from [Dr. Patel's] reports." P.A. 16a.

(4) Similarly, MetLife "credit[ed] the check-off forms" over "Dr. Patel's more detailed reports," but "*offered no explanation* for its resolution of the conflict." P.A. 20a (emphasis added).

(5) Ignoring "evidence that [was] offered after [the] initial denial of benefits" was itself "*arbitrary and capricious.*" P.A. 20a–21a (emphasis added).

(6) "[T]he occupational skills analyst and the independent medical consultant were apparently not provided with full information from Dr. Patel on which to base their conclusions." P.A. 25a; *see* P.A. 18a.

(7) Whatever one might say about the quality of the medical evidence, it is "arbitrary" and "unreasonable" to conclude that a *doctor's* "observations and notations regarding stress" can be completely ignored on the ground that they "do not constitute 'supportive medical documentation.'" P.A. 22a–23a.

As is evident from these excerpts, the Court of Appeals did not "fault[] MetLife for failing to discuss *each piece* of evidence in that file." Pet'r 45 (emphasis added). It faulted MetLife for failing to discuss "critical" evidence. P.A. 20a. It also faulted MetLife for exalting a treating physician's single "aberrational" X mark, P.A. 16a, over a consistent three-year stance that "Never" would Ms.

Glenn "be able to resume work" "*For Any Occupation*," J.A. 70, 81, 99, 110 (emphasis added)—and his subsequent insistence that he "never" intended the X to suggest otherwise, J.A. 42.[10]

In sum, if the confluence of all these flaws led the Court of Appeals to conclude that MetLife's decision "can only be described as arbitrary and capricious," P.A. 25a, there is no chance the court will describe it otherwise, regardless of the precise standards on how a conflict is supposed to be weighed.

CONCLUSION

For these reasons, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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[10] In response, MetLife repeatedly insists that Dr. Patel had concluded more than once "that Glenn could perform sedentary work," Pet'r 47; *see* Pet'r 53, 55, so that his later pleas were nothing but a "conveniently-timed change of heart," Pet'r 48, 54, "reached only after MetLife had decided to terminate Glenn's benefits, Pet'r 54. That is incorrect. *See supra* at 6. There is exactly one form in the entire record in which Dr. Patel responds that Ms. Glenn could do sedentary work. Everywhere else, Dr. Patel indicated that Ms. Glenn would "Never" return to work of any kind. *See supra* at 4-5. Moreover, a month *before* MetLife issued its denial, Dr. Patel reported (consistent with all his other reports and forms) that Ms. Glenn could not "handle any kind of stress well at her work and she would be better off being on disability." J.A. 47. This was no "change of heart," but even if it had been, it preceded MetLife's denial.

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IN THE

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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RULE 29.6 STATEMENT

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SUPPLEMENTAL BRIEF FOR PETITIONERS

Pursuant to this Court's Rule 15.8, petitioners MetLife (Metropolitan Life Insurance Company) and Long Term Disability Plan for Associates of Sears, Roebuck and Company respectfully submit this supplemental brief in response to the brief of the United States as *amicus curiae* filed on December 21, 2007.

As the United States makes clear, this Court's review is warranted to resolve "the entrenched disagreement[ ] in the courts of appeals" as to whether courts reviewing a decision by an ERISA claim administrator that both evaluates and pays claims should weigh that fact so that the standard of review is changed when reviewing the administrator's claim determination. U.S. Br. 11. Although the United States' position on the merits of that question is legally flawed, its brief removes any conceivable doubt about the compelling need for this Court to provide authoritative guidance on that important issue.

The United States is incorrect, however, when it recommends denial of review on the second question presented. That question is independently certworthy because the Sixth Circuit's holding that a claim administrator such as MetLife must always provide a written refutation of a disability determination by the Social Security Administration ("SSA") directly conflicts with the holdings of four other circuits (*see* Pet. for Writ of Cert. 17), and is inconsistent with this Court's decision in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833-34 (2003). Equally importantly, the additional question proposed by the United States—which seeks clarification of the standard for reviewing benefits determinations by claim administrators with a mere structural conflict—is legally and logically antecedent to

the question whether a court may decide that a claim administrator abuses its discretion if it does not refute an SSA disability determination in writing. Without first determining the appropriate standard of review, it is impossible to decide whether a claim administrator's failure to provide an explicit refutation of an SSA disability determination is a ground for overturning a termination of benefits. The question proposed by the United States is therefore implicit in and fairly encompassed by the second question presented.

Moreover, as the United States acknowledges, the second question presented is inextricably intertwined with the fact-intensive, totality-of-the-circumstances reasonableness inquiry that the United States proposes as the appropriate standard of review in this case. The United States is thus simply splitting hairs when it suggests that the second question presented should be briefed in conjunction with the questions on which the United States does support review, but not granted plenary review in its own right. U.S. Br. 21.

Indeed, nothing in the United States' brief ameliorates the fundamental conflict between the Sixth Circuit's holding that a claim administrator abuses its discretion if it does not refute in writing an SSA disability determination and this Court's conclusion in *Nord* that a claim administrator is not required to give special weight to—or explain its disagreement with—the views of the treating physician. 538 U.S. at 834. Because the SSA *is* required to give special weight to a treating physician's views, the Sixth Circuit's holding represents an impermissible end run around this Court's decision in *Nord*.

The petition should therefore be granted in its entirety and, if the Court concludes that a mere structural conflict of interest should be weighed so as to change the judicial standard of review of the administrator's benefit determination, it should address the additional standard-of-review question posed by the United States in conjunction with its resolution of the second question presented.

I. THIS COURT SHOULD REVIEW WHETHER A CLAIM ADMINISTRATOR THAT EVALUATES AND PAYS CLAIMS OPERATES UNDER A CONFLICT THAT CHANGES THE STANDARD OF REVIEW.

Review of the first question presented is necessary to resolve an intractable split in lower-court authority and correct the Sixth Circuit's erroneous construction of ERISA.

A. As the United States recognizes, the circuits "are clearly in disarray on the issue" whether a so-called "dual-role plan administrator"—here, a claim administrator responsible both for making benefits determinations and paying claims—should always be treated as operating under a conflict of interest that must be weighted to change the standard of review of the administrator's benefit determination. U.S. Br. 9. Indeed, "how courts should review discretionary benefits denials by potentially conflicted [claim] fiduciaries in ERISA cases has bedeviled the federal courts ever since" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), was decided. *Wagener v. SBC Pension Benefit Plan – Non Bargained Program*, 407 F.3d 395, 402 (D.C. Cir. 2005) (alteration in original; internal quotation marks omitted).

These conflicting lower-court decisions substantially undermine ERISA's objective of "ensur[ing]

that plans and plan sponsors would be subject to a uniform body of benefits law." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (internal quotation marks omitted). Without this Court's review, claim fiduciaries that make benefits determinations and pay claims will continue to be subject to one conflict-of-interest standard in the Third, Fourth, Fifth, Sixth, Eighth, Ninth, and Eleventh Circuits—which have held that a claim administrator that evaluates and pays claims is so conflicted that this fact should heighten the standard of review—and a different standard in the First and Seventh Circuits—which apply a case-by-case approach to determine whether a conflict of interest exists that alters the standard of review. *See* Pet. for Writ of Cert. 6-10.

This Court's review is urgently required to resolve this pervasive disagreement among the lower courts. This case is an ideal vehicle for resolving that split because—as the United States acknowledges—the Sixth Circuit's conclusion that MetLife was operating under a conflict of interest was essential to its decision to reinstate respondent's long-term disability benefits. *See* U.S. Br. 13 (explaining that the purported conflict of interest was one of the factors that, "'taken together,'" required reversal) (quoting Pet. App. 25a) (alteration and emphasis omitted).

B. The need for this Court's review is reinforced by the fact that the Sixth Circuit's holding—that claim administrators that make benefits determinations and pay claims are *always* so conflicted as to change the standard of review—is inconsistent with this Court's decision in *Firestone*, and with Congress's objectives when enacting ERISA.

The United States contends that, where a claim administrator both evaluates and pays claims, "every exercise of discretion impacts [the administrator] financially, filling or depleting its coffers." U.S. Br. 13 (alteration in original; internal quotation marks omitted). This facile generalization disregards the fact that Congress explicitly authorized fiduciaries to perform multiple roles. *See* 29 U.S.C. § 1102(c). It also reflects a fundamental misunderstanding of the economics of plan administration. The potential for a conflict of interest is often neutralized by other market forces—such as the insurer's incentive to "sell policies" and the employer's incentive to offer insurance programs with which its employees will be satisfied—that may offset the risk that an insurer will be "overly tight-fisted." *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (1st Cir. 2005).

Thus, while *some* claim administrators that both evaluate and pay claims may have acted due to that conflict of interest, the mere fact that an administrator performs dual functions is not sufficient, standing alone, to demonstrate the existence of a conflict that should alter the standard of review. In fact, no showing of an actual conflict was made in this case.

II. THE QUESTION WHETHER A CLAIM ADMINISTRATOR ABUSES ITS DISCRETION IF IT DOES NOT REFUTE AN SSA DETERMINATION IN WRITING ALSO WARRANTS REVIEW.

The United States' contention that this Court should deny review of the second question presented is unpersuasive. That question is eminently cert-worthy both because it fairly encompasses—and is inextricably intertwined with—the standard-of-

review question posed by the United States and because the Sixth Circuit's holding that a claim administrator abuses its discretion if it does not refute an SSA determination in writing conflicts with the decisions of other circuits and with this Court's decision in *Nord*.

A. The second question presented independently warrants review by this Court because it implicates a deep division among the circuits as to whether a claim administrator is required to refute an SSA disability determination in writing or risk the reversal of its determination. *See* Pet. for Writ of Cert. 17-19. The United States provides no persuasive basis for leaving that conflict unresolved and also fails to acknowledge that the question that it proposes for review—which asks this Court to clarify the manner in which courts should account for a conflict of interest when reviewing discretionary benefits determinations by claim administrators that both evaluate and pay claims—is an essential legal predicate to the second question presented. Indeed, a court cannot determine the legal implications of a claim administrator's failure to provide a written refutation of an SSA disability determination without first settling upon the standard to be used to review the claim administrator's decision. The question proposed by the United States is therefore fairly encompassed by the second question presented and—if the Court does conclude that MetLife was operating under a conflict of interest that alters the standard of review—should be resolved by the Court in the course of deciding the merits of that question. *See Ohio v. Robinette*, 519 U.S. 33, 38 (1996) (an "issue . . . [that] is a predicate to an intelligent resolution of the question presented" is "fairly included therein") (internal quotation marks omitted).

As the United States explains, lower courts have adopted at least three different approaches to reviewing benefits determinations by a claim administrator found to be operating under a conflict of interest: abuse-of-discretion review that takes account of a conflict of interest as one relevant factor, *de novo* review, and burden-shifting. U.S. Br. 9. This conflict can be resolved through a straightforward application of this Court's decision in *Firestone*, which held that, where a claim administrator possesses discretionary authority to determine eligibility for benefits, a "conflict must be weighed as *a factor* in determining whether there is an abuse of discretion." 489 U.S. at 115 (emphasis added; internal quotation marks and alteration omitted). *Firestone* therefore authoritatively forecloses the use of a *de novo* standard of review or burden-shifting to review a benefits determination by a conflicted claim administrator, especially one operating under a mere structural conflict. A court should instead review that decision under a reasonableness-based abuse-of-discretion inquiry that considers the totality of the circumstances surrounding the benefits determination.

The Sixth Circuit purported to apply that standard (Pet. App. 9a), but then proceeded to engage in a reevaluation of some of the medical records and other evidence before the claim administrator in what amounted to *de novo* review of the factual record. *See, e.g., id.* at 10a-24a. Moreover, at several points throughout its opinion, the Sixth Circuit faulted MetLife for allegedly failing to provide an adequate justification for its termination of respondent's benefits—an inquiry that is more consistent with other circuits' burden-shifting approach than with deferential abuse-of-discretion review. *See id.* at 22a ("the plan administrator's rejection of Dr.

Patel's assessment, under the standard set out in the plan, was, in fact, arbitrary").[1]

Under a proper application of the standard of review proposed by the United States and compelled by *Firestone*, MetLife's decision to terminate respondent's benefits should be upheld even if MetLife operated under a conflict of interest. That decision was reasonable when the totality of the factual circumstances is taken into account—including the fact that respondent's treating physician had found her "able to work in a sedentary physical exertion level occupation" at the time that MetLife terminated her benefits, but thereafter changed his conclusion although nothing changed in the underlying medical records. Pet. App. 5a.[2]

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[1] Indeed, the United States itself has recognized that claim administrators have wide discretion to decide between conflicting medical evidence when evaluating a benefits claim and that those factual determinations should not be second-guessed by a court. *See* Br. for the United States as *Amicus Curiae* at 13, *Nord* (No. 02-469) ("A plan that confers discretion on the administrator to determine whether a claimant is disabled necessarily leaves to the administrator the discretion to resolve factual disputes, such as the nature and extent of the claimant's medical condition and physical limitations.").

[2] Respondent's treating physician had determined, in an evaluation that took place in March 2002, that she was able to return to work in a sedentary position. C.A. App. 238. The United States does not mention this fact in its brief, and instead obscures the factual history by stating that the physician "*ultimately* concluded that respondent's heart condition made her unable to 'return to any kind of even sedentary work.'" U.S. Br. 3 (emphasis added). The physician, however, did not reach his "ultimate[ ] conclu[sion]"—which flatly contradicted his earlier evaluation of the same medical evidence—until July 22, 2002, seven days *after* MetLife terminated respondent's benefits. C.A. App. 172, 204, 224.

The second question presented—whether MetLife's failure to provide a written refutation of the SSA determination undercuts its termination of respondent's benefits—is inextricably intertwined with the fact-intensive, totality-of-the-circumstances reasonableness inquiry that the United States proposes as the appropriate standard of review in this case. The United States acknowledges as much, conceding that "any application of the correct legal standard to this case[ ] may involve discussion of the treatment of the SSA award as part of the reasonableness analysis" (U.S. Br. 21) and that only when "taken together" by the Sixth Circuit did the purported conflict of interest and the outdated SSA disability determination culminate in the decision to reinstate respondent's benefits. *Id.* at 13 (alteration and emphasis omitted). The United States suggests that the issue therefore warrants briefing in connection with the standard-of-review question that it proposed. *Id.* at 21.

To ensure that all issues necessary to a correct resolution of this case are adequately briefed, however, the soundest course is for this Court to grant the petition in its entirety. If this Court concludes that the administrative claim file shows that MetLife was operating under a conflict of interest so that its determination should be reviewed under the standard proposed by the United States, full briefing of the SSA issue will materially assist the Court in applying the appropriate standard of review—which encompasses *all* of the circumstances surrounding a benefits determination—to the facts of this case.

B. The United States also fundamentally mischaracterizes the second question presented, which asks this Court to resolve whether a claim administrator must refute an outdated SSA disability deter-

mination *in writing* when terminating benefits after the treating physician states the disability has been resolved. The United States recommends that this Court deny review on this question because, according to the United States, the Sixth Circuit properly decided that "MetLife should have considered the award." U.S. Br. 20. But the Sixth Circuit did not consider that the evidence supporting the SSA decision dated from the time that MetLife initially approved respondent's claim, and that the treating physician had more recently opined (in March 2002) that his patient could return to work, only to change his conclusion after MetLife acted on it to terminate further benefits in July 2002. C.A. App. 172, 204, 224, 238. It instead faulted MetLife for failing to refute the outdated SSA award as part of its written benefits determination. *See* Pet. App. 25a ("MetLife acted . . . in unacknowledged conflict with the determination of disability by the Social Security Administration.").[3]

Even if it were not inextricably intertwined with the question posed by the government, that issue would warrant review because the Sixth Circuit's conclusion that MetLife should have provided a written explanation for reaching a decision different than that of the SSA is fundamentally at odds with this Court's holding in *Nord* that claim administrators need not give special weight to—or refute in writing—a treating physician's report presented by a claimant. 538 U.S. at 834. The Sixth Circuit's re-

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[3] Indeed, it is undisputed that, before its final benefits determination, MetLife received a copy of the SSA award from respondent's attorneys (C.A. App. 167-69, 327), and discussed the award with respondent on the telephone, explaining that the denial of her continued benefits was based on all of the information available to MetLife. *Id.* at 172.

quirement that a claim administrator provide a written refutation of an SSA disability determination is flatly inconsistent with *Nord*'s conclusion that courts may not impose "a discrete burden of explanation" in writing when administrators "credit reliable evidence"—here, the treating physician's March 2002 opinion—"that conflicts" with evidence presented at the behest of the claimant. *Id.* Moreover, because the SSA—unlike a claim administrator—is required to give special weight to a treating physician's opinion (20 C.F.R. § 404.1527(d)(2)), the Sixth Circuit's written refutation requirement gives a treating physician's opinion, even if it is credible, a degree of weight that this Court explicitly rejected in *Nord*.

Notwithstanding *Nord*'s clear holding, the lower courts are divided on the frequently recurring question whether a claim administrator must refute an SSA disability determination in writing. *See* Pet. for Writ of Cert. 17-19. The conflict with *Nord* and the division among the lower courts—together with the inextricable link with the question proposed by the government—provide a compelling basis for this Court to grant review of this question.

CONCLUSION

The petition for a writ of certiorari should be granted.

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REPLY BRIEF FOR PETITIONERS

Respondent advances three principal positions in her brief: that entities that both evaluate and pay claims for an ERISA disability plan *always* operate under a conflict of interest that must be weighed on judicial review; that benefit determinations by such entities should be subject to exacting judicial scrutiny, up to and including *de novo* review; and that MetLife abused its discretion in terminating respondent's disability benefits. Respondent's arguments, like those of the United States, depart radically from this Court's existing interpretations of ERISA, from the policy objectives that animate the statute, and from the trust-law and contract principles that this Court applies when interpreting ERISA.

Respondent and the United States first contend that companies that act as fiduciaries and that separately fund claims, *without more*, operate under a conflict of interest that must be weighed on judicial review, even where the plan documents anticipate such a conflict and grant full discretion to the fiduciary. Their argument has far-reaching implications for employee benefit plans because claims under the vast majority of such plans are administered either by the employer itself or by an insurance company that funds plan benefits. Thus, under the reasoning of respondent and the United States, almost *every* discretionary benefit determination would be reviewed under a standard more rigorous than the pure abuse-of-discretion standard that plan sponsors have a contractual right to designate by delegating discretionary authority under the terms of their plans. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). This heightened scrutiny of discretionary benefit determinations would signifi-

cantly impair the contractual freedom preserved by ERISA. It would also inevitably encourage litigation by plan participants with dubious claims and—in direct contravention of ERISA's statutory objectives—dissipate plan funds that could otherwise be used to stabilize the cost of coverage or offer more generous benefits to plan participants.

Respondent and the United States further argue that, in cases where a fiduciary also funds the benefits, without more, courts should "carefu[lly] scrutin[ize]" the fiduciary's decision by "re-weigh[ing]" all of the evidence before the fiduciary under the criteria set forth in a seven-pronged test similar to the one articulated by *Abatie v. Alta Health & Life Insurance Co.*, 458 F.3d 955 (9th Cir. 2006) (en banc). Resp. Br. 44; *see also* U.S. Br. 27. This reformulation of the standard for reviewing discretionary benefit determinations of fiduciaries operating under a conflict of interest is flatly inconsistent with *Firestone*, which provides that a conflict of interest "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)) (alteration in original). The multi-pronged test proposed by respondent and the United States is also flawed from a practical standpoint because (1) it fails to provide meaningful guidance to courts, which would be left to speculate about the scope and relative weight of each factor; (2) it would likely cause courts to become preoccupied with the conflict issue and to give diminished attention to whether the actual decision was reasonable under the terms of the plan; and (3) it thwarts the goals of ERISA by encouraging class-action type discovery.

Finally, respondent's and the United States' application of their proposed standard of review to the

facts of this case mischaracterizes the administrative record and vividly highlights the flaws in their proposed multi-factor test. Indeed, they do not dispute that MetLife's conclusion that respondent did not meet the Plan's post-24-month definition of "Total Disability" was based on the fact that the opinion of her treating physician was contradicted by her medical and vocational records and four other medical opinions—including her own physician's pre-termination opinions. If MetLife's resolution of this evidentiary conflict can be second-guessed by a court, then there is virtually no benefit determination that could not be overturned on judicial review.

I. METLIFE WAS NOT OPERATING UNDER A CONFLICT OF INTEREST THAT MUST BE WEIGHED ON JUDICIAL REVIEW WHEN IT TERMINATED RESPONDENT'S BENEFITS.

ERISA's text, structure, and purpose establish that entities that both evaluate and pay benefit claims do not, without more, operate under a conflict of interest that must be weighed on judicial review. In an effort to circumvent the clear implications of these interpretive guideposts, respondent and the United States marginalize ERISA's statutory text, invoke irrelevant trust-law principles that post-date ERISA's enactment, and adopt a restrictive view of ERISA's statutory objectives. None of these arguments can conceal the flaws in the court of appeals' conclusion that MetLife was operating under a conflict of interest of such weight when it terminated respondent's benefits that its reliance on persuasive medical and vocational information was wrong.[1]

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[1] As an initial matter, respondent observes that "[m]ost circuits disagree with MetLife's position" in this case. Resp. Br.

A. Respondent's Arguments Conflict With The Language, Structure, And Purpose Of ERISA.

1. In contending that entities that both evaluate and pay claims always operate under a conflict of interest that must be weighed on judicial review, respondent and the United States disregard the most relevant textual provisions of ERISA. For example, although respondent acknowledges that ERISA explicitly "authorizes" an employer—or any agent of the employer—responsible for funding a benefit plan to serve in a fiduciary capacity as claim administrator, she contends that this provision does not "say anything" about whether such a company is operating under a conflict of interest that must be weighed on judicial review. Resp. Br. 20 (citing 29 U.S.C. § 1108(c)(3)) (emphasis omitted). If Congress believed, however, that all entities that both evaluate and pay benefit claims are operating under a conflict of interest that is potentially detrimental to plan participants and that requires heightened judicial review, it is inconceivable that it would have provided express authorization for this arrangement.

Respondent and the United States nevertheless proceed as if ERISA were silent on this issue and se-

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[Footnote continued from previous page]

12. *Firestone* itself makes clear, however, that this Court has never hesitated to endorse interpretations of ERISA previously rejected by a majority of circuits. 489 U.S. at 109, *see also Buckhannon Bd. & Care Home, Inc. v. W. Va. Dep't of Health & Human Res.*, 532 U.S. 598, 621 (2001) (Scalia, J., concurring) ("[O]ur disagreeing with a 'clear majority' of the Circuits is not at all a rare phenomenon. Indeed, our opinions sometimes contradict the *unanimous* and long-standing interpretation of lower federal courts.").

lectively highlight other aspects of the statutory scheme. The United States, for example, emphasizes that "Congress imposed strict standards of loyalty and care" when it enacted ERISA and that it "intended in particular to prevent trustees from engaging in actions where there would be a conflict of interest." U.S. Br. 17 (internal quotation marks omitted). But these observations ignore the explicit *exception* to these background principles created by 29 U.S.C. § 1108(c)(3). The United States also disregards the fact that ERISA gives such wide discretion to employers in structuring their plans—to which the duty of loyalty and care runs—that it expressly authorizes a fiduciary to have "financial interests adverse to beneficiaries" as long as the fiduciary does not act upon those interests when making fiduciary decisions. *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

Requiring courts to weigh on judicial review as a purported "conflict" the bare fact that a fiduciary is responsible for paying claims, without evidence that the fiduciary's decision was infected by self-dealing, is also inconsistent with the fact that "[n]either general principles of trust law nor a concern for impartial decisionmaking . . . forecloses parties from agreeing upon a narrower standard of review" than the default *de novo* standard. *Firestone*, 489 U.S. at 115; *see also* Br. for the United States as Amicus Curiae at 13, *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003) (No. 02-469) ("employers are free under ERISA to design plans that grant discretion to the plan administrator to interpret plan terms and make eligibility determinations"). In accordance with this principle, the Court has stated that, where a "benefit plan gives the . . . fiduciary discretionary authority to determine eligibility for benefits," the

fiduciary's decision will be reviewed for an abuse of discretion. *Firestone*, 489 U.S. at 115.[2]

Respondent and the United States, however, would effectively rewrite ERISA to provide that employers may not elect a pure abuse-of-discretion standard of review for benefit determinations if the entity deciding claims is also the source of funding. If this Court adopted the position advocated by respondent and the United States, benefit determinations would *rarely* be subject to the pure abuse-of-discretion standard of review because, under the vast majority of plans, claims are administered either by insurance companies or by employers responsible for providing the funding.

Indeed, under the position of respondent and the United States that any potential financial interest in a transaction—no matter how attenuated—gives rise to a conflict of interest that must be weighed on judicial review, even an independent third party hired by a plan sponsor to make benefit determinations could be allegedly operating under such a conflict because the claim administrator would theoretically have an incentive to deny borderline claims in order to minimize the plan sponsor's costs and augment its chances of being rehired. The concern about the breadth of these conflict arguments is far from theoretical, as similar challenges to the impartiality of third-party claim administrators have been raised in the past. *See, e.g.*, *Weidner v. Fed. Express Corp.*, 492 F.3d 925, 930 (8th Cir. 2007). Thus, if the decision below were affirmed, there could be virtually no

[2] For this reason, it is irrelevant that, prior to the enactment of ERISA, an employee's breach-of-contract action alleging that the insurer had wrongfully withheld benefits would have resulted in *de novo* review of the claim. Resp. Br. 14.

situation in which courts would apply the abuse-of-discretion standard. The Court should reject this backdoor effort to overrule *Firestone*'s holding that employers may decide to alter the default *de novo* standard of review under the terms of the plan.[3]

2. Respondent and the United States also misconstrue the trust-law principles that served as the backdrop for ERISA's enactment and that inform its interpretation.

As an initial matter, both respondent and the United States rely heavily on the Restatement (Third) of Trusts to support their position that every potential conflict of interest must be weighed on judicial review of a claim determination, even if there is no indication that the fiduciary's decision-making was infected by that conflict. *See, e.g.*, Resp. Br. 24, 25, 42; U.S. Br. 14, 24, 25. But the Restatement (Third) sheds little, if any, light on Congress's intentions when enacting ERISA because it was published

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[3] Respondent misreads *Firestone* when she suggests that the threshold conflict-of-interest issue in this case is controlled by the Court's statement that, where a "fiduciary . . . is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d) (alteration in original). Although that statement certainly provides guidance regarding the standard to be employed in reviewing a benefit determination by a fiduciary who was *actually influenced* by self-interest, it does not answer the question whether a fiduciary that both evaluates and pays claims is *always* "operating under" a conflict of interest that must be weighed on judicial review. The Court's statement merely reflects the trust-law principle that a conflict must be weighed as a factor where it is shown that the trustee is "operating under"—i.e., influenced by—its own self-interest. *See also infra* note 4.

more than a quarter century *after* ERISA was enacted. *See Director v. Greenwich Collieries*, 512 U.S. 267, 275 (1994) ("We . . . presume Congress intended [a] . . . phrase to have the meaning generally accepted in the legal community at the time of enactment."). Indeed, this Court has never cited it when interpreting ERISA and has instead relied upon the Restatement (Second) of Trusts to illuminate Congress's intentions when enacting ERISA. *See, e.g., LaRue v. DeWolff, Boberg & Assocs.*, 128 S. Ct. 1020, 1024 n.4 (2008).

The Restatement (Second) makes clear that, where a potential conflict of interest is contemplated by the trust documents, that conflict is taken into account *only* when there is evidence suggesting that the trustee's decision-making was infected by that conflict. The Restatement (Second) explains, for example, that "[a]lthough ordinarily the court will not inquire into the motives of the trustee, yet if it is shown that his motives were improper or that he could not have acted from a proper motive, the court will interpose." Restatement (Second) of Trusts, § 187 cmt. g. The Restatement (Second) provides the following illustration:

> A devises Blackacre to B in trust and directs B to sell Blackacre if in his judgment such sale would be for the best interest of the beneficiaries. It clearly appears that a sale would be highly advantageous to the beneficiaries, but B refuses to sell the land solely on the ground that the purchaser would probably use the land in a manner to cause a depreciation in value of B's own land situated nearby. The court may order a sale of land.

Id. § 187 cmt. g, illus. 2.

Under the Restatement (Second), then, courts may overturn the decision of a trustee with a potential conflict of interest only when it is "shown" that the trustee acted under the influence of that interest when making a decision. Courts do not take account of a *potential* conflict of interest where there is no indication that the trustee actually acted on the basis of that interest. *See, e.g., In re Pincus' Estate*, 105 A.2d 82, 86 (Pa. 1954) (where a conflict of interest was contemplated in the trust, a trustee's discretionary decision cannot be overturned unless "bad faith on the part of the fiduciary [is] affirmatively shown"); *Gregory v. Moose*, 590 S.W.2d 665, 670 (Ark. Ct. App. 1979) (refusing to invalidate a transaction from which a trustee benefited personally because the transaction was contemplated by the settlor and was not "dishonest, or fraudulent, or intentionally detrimental to one or more beneficiaries").[4]

Applied in the ERISA setting, this trust-law principle establishes that, where a fiduciary has an interest that is potentially adverse to that of a plan participant, the fiduciary's decision can only be overturned on the basis of that potential conflict where the plaintiff "show[s]" that the fiduciary acted im-

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[4] Comment d to Section 187 of the Restatement (Second), invoked by respondent (at 24-25), is not to the contrary. It merely provides that the "existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries" "*may* be relevant" to determining whether the trustee abused its discretion. As comment g to Section 187, and its illustrations, make clear, the existence of such an interest is *not* relevant on judicial review where the potential conflict is contemplated in the trust documents and there is no evidence that the trustee's decision was infected by self-dealing.

properly to further its own interests. Absent such a showing, however, the potential conflict of interest may not be weighed on judicial review of a benefit determination by the fiduciary. *See also infra* Section I.A.3 (duty of loyalty is due to the plan itself and *all* participants and beneficiaries).

Moreover, even if trust law did support the position of respondent and the United States, trust law is merely a "guide[ ]" for construing ERISA. *Firestone*, 489 U.S. at 111. This Court does not invariably adhere to trust law's guidance where other indicia of statutory meaning—such as the text and purpose—yield a different result. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 219 (2002) (deeming trust-law principles to be "inapposite" because the relief sought was foreclosed by ERISA's plain language); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 259 (1993) ("The authority of courts to develop a 'federal common law' under ERISA is not the authority to revise the text of the statute."). Here, the statutory text of ERISA unambiguously establishes that Congress did not consider entities that both evaluate and pay claims, without more, to be operating under a conflict of interest and did not intend to restrict employers' freedom to design a plan subject to a standard of review different than ERISA's default standard. To the extent there is any inconsistency between trust law and these statutory principles, the conflict would have to be resolved in favor of ERISA's text.

3. Respondent and the United States are equally unsuccessful in their effort to reconcile the Sixth Circuit's holding with ERISA's dual policies of encouraging the formation of employee benefit plans and protecting the interests of all plan participants.

Respondent and the United States essentially contend that any procedural rule that increases the likelihood that an individual plan participant will receive benefits is consistent with ERISA's objectives. But this simplistic characterization of ERISA's goals overlooks the fact that "a fiduciary obligation, enforceable by beneficiaries seeking relief for themselves, does not necessarily favor payment over nonpayment." *Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996). "The common law of trusts," the Court has explained, "recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries." *Id.* (citing Restatement (Second) Trusts §§ 183, 232). The fiduciary obligations of ERISA claim administrators therefore run not only to individual plan participants but also to the plan as a whole. The fiduciary duties that bind claim administrators thus strongly favor the denial of nonmeritorious claims and the preservation of plan funds for the payment of claims filed by participants who satisfy the plan's benefit requirements. *See Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 807 (10th Cir. 2004) ("a fiduciary has a duty to protect the plan's assets against spurious claims").[5]

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[5] Indeed, the Plan's post-24-month definition of "Total Disability" is very restrictive—requiring the claimant to demonstrate that she is "totally incapable of performing the material duties of any gainful occupation for which [she is] reasonably qualified" (J.A. 160a)—in part due to the ethical hazard created by the availability of disability benefits. To ensure that the cost of sponsoring the plan does not become prohibitively expensive for the employer or other participants, an administrator in MetLife's position must carefully scrutinize benefit claims for compliance with the definitions set forth in the plan.

Accordingly, ERISA's procedural framework is not designed simply to maximize the chances that judicial review will culminate in a decision that a participant is entitled to benefits. Courts are required to review a benefit determination in a manner that distinguishes between meritorious and nonmeritorious claims and that therefore furthers ERISA's objective of minimizing the "administrative and financial burdens on plan administrators." *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001) (internal quotation marks omitted). Recasting and diluting the pure abuse-of-discretion standard of review specified in the plan documents based on the mere fact that an entity both evaluates and pays claims, without any indication that the benefit determination was infected by self-interest, increases the likelihood that participants with questionable claims will file suit. That in turn increases the likelihood that the plan will be compelled to pay additional litigation costs (and, if the suit is successful, unwarranted benefits) with funds that could otherwise have been used to stabilize premiums or to allow enhanced coverage to other plan participants.

Respondent's contention that there is no empirical evidence that a heightened standard of review for claim denials fosters litigation disregards the realities of ERISA litigation. Federal courts are asked to resolve nearly ten thousand ERISA claims every year. Administrative Office of the United States Courts, *Judicial Business of the United States Courts* tbl. c-2 (2008). Because the majority of circuits are now applying the conflict-of-interest rule that respondent urges—holding that entities that both evaluate and pay claims always operate under a conflict of interest that must be weighed on judicial review—it is reasonable to conclude that the large vol-

ume of ERISA litigation is attributable at least in part to the heightened standard of review. It stands to reason that disappointed claimants are more likely to file suit where a court will closely scrutinize the claim administrator's decision under an open-ended and malleable multi-factor test than where the court will apply a more deferential and predictable abuse-of-discretion standard of review. Indeed, in the four years after this Court's holding in *Firestone* that the default standard under ERISA is *de novo* review (rather than the arbitrary-and-capricious standard that had been adopted by most circuits), the volume of ERISA litigation increased by seventeen percent, which leaves little doubt about the connection between heightened judicial review of benefit determinations and increases in litigation volume. *Compare* Administrative Office of the United States Courts, *Judicial Business of the United States Courts* tbl. c-2 (1995) (1994 caseload figures), *with* Administrative Office of the United States Courts, *Judicial Business of the United States Courts* tbl. c-2 (1991) (1990 caseload figures).

4. In sum, neither respondent nor the United States has provided any basis for overriding the provision of the present benefit plan calling for pure abuse-of-discretion review of MetLife's benefit determinations. That provision states unequivocally that MetLife "shall have the *discretionary* authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits" and that "*[a]ny* interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was *arbitrary and capricious*." J.A. 181a-82a (emphases added). Respondent and the United States believe

ERISA necessarily overrides that provision and requires the application of a *modified* abuse-of-discretion standard in which a judicial thumb—of at least some weight—is placed on the scale. There is simply no warrant, however, in ERISA, its history, or the policies that underlie the statute for such an automatic modification of the pure abuse-of-discretion standard that the employer designated and on which MetLife relied when underwriting the Plan's insurance coverage.

B. Respondent's Characterization Of The Insurance Business Is Simplistic And Wrong.

Respondent and the United States contend that the claim determinations of MetLife and other fiduciaries that both evaluate and pay claims should be scrutinized more closely than the plan allows because, in their view, such companies have "a financial stake in every claim for benefits that is submitted under the plan." Resp. Br. 12; *see also* U.S. Br. 16 ("a plan administrator is better off financially when it does not pay benefits"). This simplistic understanding of the insurance business—under which every dollar that a company pays out on a claim comes directly out of the company's "own pocket" and diminishes its profits (Resp. Br. 12)—ignores the sophisticated financial mechanisms that insurance companies use to spread risk and to ensure that they have adequate funds to pay claims while still earning a profit.

This Court has recognized that the "spreading of risk" is "an indispensable characteristic of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 212 (1979). Indeed, neither respondent nor the United States disputes that insur-

ance companies utilize a number of financial tools—such as reserves, manual rating, and experience rating—to manage risk and to diminish the financial impact that any one claim for benefits will have upon the company's bottom line. *See, e.g.*, Va. Code Ann. § 38.2-1311 (requiring disability insurers to maintain a reserve calculated based on potential liabilities); Wash. Rev. Code § 48.12.060 (same); *see also* ACLI Br. 13-16.

Respondent instead suggests that, where such mechanisms are in place, the fiduciary should introduce an affidavit outlining these measures and that, under such circumstances, courts may take these factors into account in determining the level of scrutiny to be applied when reviewing a benefit determination of a fiduciary that both evaluates and pays claims. The point, however, is that these economic features are characteristic of the insurance business as a whole, not idiosyncratic details that only appear in unusual cases and that must be affirmatively set forth and pleaded. Moreover, imposing the burden of production on the insurance company is fundamentally inconsistent with the settled rule that the burden of proof in an ERISA action challenging a claim denial rests on the plaintiff. *See, e.g.*, *Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 270 (4th Cir. 2002); *see also* U.S. Br. 26 (acknowledging that burden-shifting would be detrimental).

Respondent's suggestion that this sort of inquiry would impose only minimal burdens on claim administrators and courts also is misguided because the introduction of such an affidavit would merely be used as the occasion for claimants to conduct "big case," full-blown discovery into any business practices described in the affidavit—discovery wholly unrelated to the benefit determination at issue. *See,*

e.g., *Abatie*, 458 F.3d at 969 & n.7 (suggesting that an ERISA claim defendant should produce "affirmative evidence" that it was not operating under a conflict). Such evidentiary inquiries into risk-spreading mechanisms properly rest within the province of state insurance regulators, rather than federal courts. *See* McCarran-Ferguson Act, 15 U.S.C. § 1011. Costly and inefficient discovery into threshold conflict-of-interest issues is also squarely at odds with Congress's intention that ERISA claims litigation proceed in a cost-effective and streamlined manner. *See Varity Corp.*, 516 U.S. at 497. To that end, courts adjudicating ERISA claims generally limit their review to the record developed during the administrative process. *See, e.g.*, *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608-09 (4th Cir. 1999); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990). The requirement that ERISA claimants, like parties challenging an agency decision, exhaust administrative remedies before filing suit in federal court further indicates the importance of ERISA's goal of minimizing litigation and its costs. *See, e.g.*, *Weldon v. Kraft, Inc.*, 896 F.2d 793, 800 (3d Cir. 1990) ("a federal court will not entertain an ERISA claim unless the plaintiff has exhausted the remedies available under the plan"); *see also* 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(h).

Respondent and the United States also improperly discount insurance companies' powerful reputational incentive to decide benefit claims in a manner that fairly and faithfully implements the terms of the plan. One need look no further than UnumProvident, which experienced a serious reduction in its market share after it became public that the company had engaged in the systematic denial of meritorious benefit claims, to appreciate the importance of

business reputation to disability benefit insurers. *See* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. L. Rev. 1315, 1317 n.11 (2007). Because employers offer benefit plans to foster employee loyalty and improve morale, an insurance company that acquires a reputation for denying meritorious claims will inevitably lose business to competitors that have better track records. *See Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998).

Finally, respondent is unable to distinguish meaningfully between insurance company claim examiners and administrative law judges ("ALJs"), who are not considered to be operating under a conflict of interest even though they decide monetary claims against their employer, the federal government. Respondent emphasizes that ALJs "are public employees bound by a well established set of procedural protections." Resp. Br. 36 (internal quotation marks omitted). ERISA, too, binds claim fiduciaries to act solely in the interest of all plan participants and beneficiaries (29 U.S.C. § 1104(a)(1)), and, in making benefit determinations, they are subject to extensive procedural requirements imposed by the Department of Labor (*see, e.g.*, 29 U.S.C. § 1133(1); 29 C.F.R. § 2560.503-1).

Moreover, respondent and the United States are incorrect when they suggest that the abuse-of-discretion standard that *Firestone* specified for discretionary benefit determinations is qualitatively different from the standard applied under the Administrative Procedure Act ("APA") to agency decisions. Resp. Br. 43; U.S. Br. 29 n.3. Courts have long recognized that whether the standard of review for dis-

cretionary benefit determinations is given the "abuse of discretion" or "arbitrary and capricious" label, it is analogous to review of agency decision-making under the APA. Indeed, relying on then-Judge Ginsburg's opinion in *Block v. Pitney Bowes Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992), the United States itself has previously acknowledged as much. *See* Br. for the United States as Amicus Curiae at 13-14, *Nord* (No. 02-469).

Thus, just as ALJs are not presumed to be biased in favor of their employer simply because the federal government has a financial interest in the claims they decide, ERISA claim administrators should not be deemed to operate under a conflict of interest unless there is evidence in the administrative record that their decision-making was infected by concerns about their employer's financial interests.[6]

C. Respondent Improperly Discounts The Regulatory Safeguards That Protect Plan Participants From Biased Decision-Making.

Respondent suggests that oversight of insurance companies that serve as plan fiduciaries by the De-

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[6] The United States also attempts to distinguish claim examiners and ALJs on the ground that "the federal government itself, unlike an insurance company, is not a for-profit institution." U.S. Br. 21. The United States is wrong to suggest that all insurance companies are for-profit entities. *See, e.g., Lee v. Blue Cross/Blue Shield of Ala.*, 10 F.3d 1547, 1552 n.6 (1994) (noting Blue Cross' status as a not-for-profit entity). But even where a claims examiner is employed by a for-profit enterprise, the theoretical incentive to maximize his employer's profits is no different than a government employee's incentive to please his superiors by saving the federal government money and preserving the limited budget of the agency by which he is employed.

partment of Labor and state insurance departments "is no substitute" for courts' consideration of individual benefit determinations. Resp. Br. 39. But the fact that state and federal regulatory oversight, on the one hand, and judicial review under ERISA, on the other, may serve complementary functions does not mean that courts are free to alter the standard of review that the employer intends by delegating discretionary authority to its funding source under the terms of its plan. Much less does it establish that federal courts should become *ad hoc* insurance regulators by conducting detailed evidentiary reviews of actuarial assumptions, risk spreading, and other similar factors that are wholly unrelated to the benefit determination. It instead establishes simply that plan participants should be given the opportunity to seek court-ordered relief from unreasonable claim denials. ERISA and the plan documents here guarantee plan participants that right, as well as the opportunity to seek full and fair review of benefit determinations through insurance companies' internal administrative review processes. *See* AHIP Br. 13.

The aberrant example of UnumProvident, which respondent invokes (at 17) in an effort to demonstrate the necessity for heightened scrutiny, merely reinforces the fact that state regulators will inevitably uncover—and remediate—any systematic wrongdoing by insurance companies. Judicial review under the traditional abuse-of-discretion standard—in combination with administrative review through an insurance company's internal procedures and with federal and state regulatory oversight—is thus sufficient to uncover similar episodes. Indeed, although the National Association of Insurance Commissioners suggests otherwise, it is passing strange for regulators to disavow their ability to uncover potential

abuse by holding up an example of an abuse that was actually uncovered by their efforts. *See* NAIC Br. 13.

II. If MetLife Is Deemed To Be Operating Under A Conflict Of Interest That Must Be Weighed On Judicial Review, The Conflict Should Be Only One Factor Considered In Determining Whether MetLife Abused Its Discretion.

Firestone establishes that, if an entity that both evaluates and pays claims is operating under a conflict of interest that must be weighed on judicial review, that conflict should be weighed as only one factor in determining whether the entity abused its discretion in denying or terminating benefits. Echoing the Ninth Circuit's decision in *Abatie*, however, respondent and the United States disregard this Court's guidance in *Firestone* and instead propose a nonexclusive list of seven factors to be used in determining the degree of deference afforded to the decisions of a conflicted fiduciary. Respondent's proposed standard is legally flawed and also suffers from serious practical shortcomings. Not the least of these shortcomings is respondent's newly minted contention that this case should be resolved under *de novo* review. *Compare* Resp. Br. 49, *with* Br. in Opp. 24 (endorsing heightened abuse-of-discretion review).[7] If this case is an appropriate candidate for *de novo* review, it is difficult to conceive of any case in-

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[7] Before the court of appeals, respondent observed that MetLife both evaluated and paid benefit claims, but never asserted that it was actually operating under an improper motive. *See* Resp.'s C.A. Opening Br. 22.

volving at least some conflicting medical evidence where *de novo* review would not be appropriate.

A. Respondent's Proposed Standard Of Review Is Inconsistent With This Court's Precedent And With ERISA's Statutory Objectives.

In *Firestone*, this Court made clear that, where a "fiduciary . . . is operating under a conflict of interest," that conflict is to be "weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d) (alteration in original). Respondent acknowledges the standard articulated in *Firestone*, but then proposes that courts apply it in a manner that is more akin to *de novo* review than to the traditional arbitrary-and-capricious standard specified in *Firestone*. Specifically, respondent suggests that courts "re-weigh the evidence" before the fiduciary and require "complete and careful explanations," while "cast[ing] a skeptical eye on the explanations they do receive" and "exhibit[ing] little tolerance for analytical flaws or evidentiary gaps." Resp. Br. 44.

Respondent's proposed modification to the abuse-of-discretion standard is directly at odds with this Court's holding in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), that ERISA does not "impose on plan administrators a discrete burden of explanation" in writing when they "credit reliable evidence that conflicts" with evidence presented by the claimant. *Id.* at 834. Respondent's contention that fiduciaries that are operating under a conflict of interest should be required to "provide complete and careful" explanations of every aspect of their decision cannot be reconciled with this aspect of *Nord*.

Moreover, the suggestion of respondent and the United States that courts should "diminish[ ] deference" to a fiduciary's decision based on a panoply of factors—ranging from "reversal of position without additional medical evidence" to "denying disability after advocating disability to the SSA" (Resp. Br. 49; U.S. Br. 27)—is both practically flawed and legally erroneous. From a practical standpoint, encouraging courts to consider an ill-defined range of factors extrinsic to the administrative record would inevitably invite costly and time-consuming discovery in a number of otherwise routine benefit cases, in direct contravention of Congress's "desire" in enacting ERISA "not to create a system that is so complex that . . . litigation expenses[ ] unduly discourage employers from offering welfare benefit plans." *Varity Corp.*, 516 U.S. at 497. The prospect of potentially onerous discovery in virtually every run-of-the-mill benefit case is likely to discourage employers from establishing benefit plans in the first instance and to compel insurance companies to increase premiums for existing plans—thereby exacerbating financial burdens on employers and/or participants, and likely prompting a reduction in the generosity of plan benefits. *See Newman v. Standard Ins. Co.*, 997 F. Supp. 1276, 1280-81 (C.D. Cal. 1998) (noting the "immense practical problems associated with" discovery into whether a fiduciary was operating under a conflict of interest, which could result in the "expense of ERISA litigation . . . easily be[ing] more than the benefits at issue").

Moreover, such multi-factored tests are invariably difficult "to apply, jettisoning relative predictability for the open-ended rough-and-tumble of factors." *Jerome B. Grubart, Inc. v. Great Lakes Dredge & Dock Co.*, 513 U.S. 527, 547 (1995). Indeed, the

Court has experimented with multi-pronged standards in the past (*see, e.g.*, *Relford v. Commandant*, 401 U.S. 355, 365 (1971) (12-factor test)), only to abandon them as unworkable in later cases due to the "confusion" they inevitably generate (*Solorio v. United States*, 483 U.S. 435, 449 (1987)). This is a particular concern here, where the determinations are highly fact-sensitive and individualized. Adopting respondent's malleable slate of subjective factors would deprive the lower courts of meaningful guidance and inevitably generate uncertainty for plan sponsors, fiduciaries, and participants.[8]

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[8] Moreover, the application of those factors to the facts of this case would not warrant a reduction in the deference due MetLife's benefit determination, nor does respondent explain how they could. First, MetLife did not "revers[e] [its] position without additional medical evidence." Resp. Br. 49. The Plan's definition of disability became more restrictive after two years. This Plan change required the termination where undisputed medical evidence showed that respondent's cardiac condition had stabilized. J.A. 23a, 25a. Nor did MetLife "'self-servingl[y]'" disregard Dr. Patel's reports that supported respondent's position. MetLife noted Dr. Patel's post-denial opinions that respondent was disabled from sedentary work, but concluded that they were outweighed by contrary medical evidence and physicians' opinions. *Id.* at 25a-26a. Furthermore, MetLife did not provide inconsistent reasons for its termination of respondent's benefits. It instead consistently explained that the medical evidence did not support a finding that respondent was disabled from performing any occupation. *Id.* And MetLife did not terminate respondent's benefits without an investigation into its merits. It conducted a thorough inquiry into her claim, obtaining the opinions of an in-house nurse consultant and two independent physicians, as well as a transferable skills analysis. Nor did MetLife "'fail[ ] to credit'" respondent's "reliable evidence"; rather, it reasonably concluded that her physician's post-denial opinions were unreliable and were outweighed by other, more reliable evidence that she was capable

B. Respondent's Reading Of The Administrative Record Is Flawed.

Whatever the appropriate standard of review in this case—the *de novo* standard urged by respondent, the watered-down abuse-of-discretion standard endorsed by the United States, or the fully deferential abuse-of-discretion standard advocated by MetLife—respondent and the United States are wrong to suggest that MetLife improperly terminated respondent's long-term disability benefits or that its decision-making process was flawed.

Contrary to respondent's assertion, MetLife's termination of Glenn's benefits was premised on much more than Dr. Patel's supposedly "aberrational X." Resp. Br. 5. As an initial matter, Dr. Patel's statement that respondent was "able to work in a sedentary physical exertion level occupation" was hardly aberrational or careless. J.A. 58a. In the same document, Dr. Patel responded "N/A" when asked to "explain current physical barriers preventing Ms. Glenn from returning to fulltime" (*id.*)—a clear indication that Dr. Patel understood that, when checking "yes" to the earlier question, he was communicating to MetLife that respondent was capable of performing full-time sedentary work. This opinion was consistent with Dr. Patel's conclusions in both January and June 2002, with the opinions of three other independent physicians (Pet. App. 45a; J.A. 37a, 54a-56a, 59a-61a; C.A. App. 170), and with the fact that, when

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[Footnote continued from previous page]

of sedentary work. *Id.* at 25a-26a. Finally, MetLife did not "'advocat[e]'" disability to the SSA. MetLife neither appeared in those proceedings nor directed respondent's lawyers on the exercise of their professional judgment.

her benefits were terminated, respondent's heart function had significantly improved from the time that she first started receiving disability benefits. J.A. 74a.

Respondent's contention that MetLife should have disregarded Dr. Patel's pre-denial opinions, the conclusions of these three other independent physicians, and the medical evidence contradicting the opinion that Dr. Patel expressed during the administrative review process effectively seeks to overturn this Court's conclusion in *Nord* that claim administrators are not "require[d]" to "accord special weight to the opinions of a claimant's physician." 538 U.S. at 834.[9] Deference to the treating physician would be especially inappropriate in this case, where each of Dr. Patel's post-denial letters contained material statements that are impeached by objective evidence, some from his own records. *Compare* J.A. 44a ("patient has tried to return to work"), *with id.* 19a, ¶ 2 ("Per C[ase]M[anager]S[pecialist,] E[mploye]R interview 8/9/02 there was no prior R[eturn]T[o]W[ork] since disability" began); *compare id.* 42a (the implanted cardiac "device has no roll [sic] in terms of improving her cardiac function"), *with id.* 75a (new biventricular pacing device implanted).

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[9] This case does not even present the classic scenario of treating physician opinion versus insurance company medical director opinion because MetLife never inquired of any staff physician, and relied heavily on the reliable information supplied by the treating physician himself. J.A. 59a-60a, 57a-58a, 54a. The determination of which of the treating physician's opinions to credit—pre- or post-denial of benefits—was based on the objective medical testing in the treating physician's own files (*id.* at 46a; C.A. App. 228), and the opinions of three independent physician consultants, one of whom was not even hired by the Plan for an opinion. Pet. App. 45a; J.A. 37a; C.A. App. 170.

None of the other purported flaws in MetLife's reasoning identified by the court of appeals and respondent warrants reinstatement of respondent's disability benefits. For example, under *Nord*, MetLife was not required to provide a written explanation for its decision not to defer to the findings of the SSA proceedings. 538 U.S. at 834. Moreover, because *Nord* held that a claim administrator—unlike the SSA (20 C.F.R. § 404.1527(d)(2))—is not required to give special weight to a treating physician's opinion, respondent's argument that MetLife was required to refute the SSA determination gives a treating physician's opinion a degree of weight that this Court explicitly rejected in *Nord*. The result of the SSA proceeding is inapposite, in any event, because respondent bore the burden of proving to MetLife that she was totally disabled, whereas the government bore the burden of establishing that respondent was capable of returning to full-time work in the SSA proceeding.[10]

Respondent is also wrong when she suggests that MetLife itself argued to the SSA that she was entitled to government benefits. In accordance with its standard practice under plans that offset estimated and actual social security benefits, MetLife recommended a law firm specializing in social security claims, which respondent selected to represent her in the SSA proceeding. MetLife did not participate in

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[10] Respondent faults MetLife for addressing the court of appeals' misplaced reliance on the SSA determination in its opening brief. Resp. Br. 52. As the United States itself recognized, however, "any application of the correct legal standard to this case[] may involve discussion of the treatment of the SSA award as part of the reasonableness analysis." U.S. Cert. Br. 21.

that proceeding and never argued to the SSA that respondent was disabled. Moreover, recommendation of counsel was consistent with MetLife's fiduciary obligation to the plan to ensure that beneficiaries with alternative sources of disability payments receive those awards and reimburse the Plan for overpayments.[11]

Similarly, respondent faults MetLife for failing to provide a "'reason for rejecting'" Dr. Patel's post-denial, inconsistent opinion that respondent was disabled from sedentary work (Resp. Br. 54-55 (quoting Pet. App. 19a)) and for "'offer[ing] no explanation for its resolution of the conflict'" between Dr. Patel's divergent views of respondent's ability to return to work. *Id.* at 55 (quoting Pet. App. 20a) (emphasis omitted). But respondent again disregards *Nord*'s holding that ERISA does not "impose on plan administrators a discrete burden of explanation." 538 U.S. at 834. Moreover, although MetLife was under no obligation to explain its reasons for concluding that Dr. Patel's conveniently-timed reassessment of respondent's medical condition was not credible, it in fact did so, in exactly the manner that the United States recently endorsed. *See* Br. for the United States as Amicus Curiae at 15, *Nord* (No. 02-469) ("the reasons that an administrator did not rely on the treating physician's opinion may reasonably be

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[11] MetLife's recommendation was also consistent with respondent's best interests because, for example, the Plan does not offset social security cost-of-living adjustments. J.A. 169a; *see also id.* at 145a-46a (October 10, 2000, letter explaining other advantages to respondent). The United States also mistakenly contends that "MetLife directed respondent to apply for Social Security disability benefits." U.S. Br. 4. As respondent herself acknowledges, however, she applied for SSA benefits without any prompting from MetLife. Resp. Br. 4 n.2.

apparent from other medical evidence, . . . tests, or examinations, as well as non-medical evidence, that rebut the opinion of the treating physician regarding the claimant's condition or limitations"); *see also* J.A. 31a-32a (explaining that there were no post-disability medical records of decompensation from stress and that several types of full-time sedentary work fit respondent's medical criteria and were, on their face, low stress); *id.* at 25a (explaining the role of respondent's biventricular pacemaker in improving her condition, and other objective medical test results). Under both ERISA and the plan documents, the resolution of this factual issue rested in the sound discretion of MetLife, was reasonable, and may not be second-guessed by a court.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY), ET AL., PETITIONERS

v.

WANDA GLENN

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT

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QUESTIONS PRESENTED

1. Whether an insurance company or other administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is operating under a conflict of interest that must be weighed on judicial review of a benefit determination.

2. If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT

INTEREST OF THE UNITED STATES

This case concerns the standard a court should use to review a denial of plan benefits by an administrator of an employee benefit plan governed by Title I of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.* The Secretary of Labor has primary authority for enforcing and administering Title I of ERISA to ensure fair and impartial plan administration and compliance with ERISA's requirements. At the invitation of the Court, the United States filed a brief as amicus curiae at the petition stage of this case.

STATEMENT

1. The Employee Retirement Income Security Act, 29 U.S.C. 1001 *et seq.*, was enacted to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of [those] plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b). As part of its comprehensive enforcement scheme, ERISA authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. 1132(a)(1)(B).

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), this Court considered the appropriate standard of review in an action to recover benefits under an ERISA plan. *Id.* at 108. Noting that Congress did not specify a standard, the Court turned to the purposes of ERISA and its basis in trust law. *Id.* at 108-115. It concluded "that a denial of benefits * * * is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case abuse-of-discretion review applies. *Id.* at 115. The Court noted, however, that more searching review is necessary in the case of a conflicted decisionmaker: "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Ibid.* (quoting Restatement (Second) of Trusts § 187 cmt. d at 403 (1959) (Second Restatement)).

2. Respondent worked for Sears, Roebuck and Company (Sears) from 1986 until 2000. Pet. App. 2a-3a. She participated in a Sears-sponsored disability benefit plan governed by ERISA. J.A. 181a. The plan provided disability benefits in two stages. In the first stage, a person was totally disabled when she was unable to perform her regular job. Pet. App. 3a. In the second stage, which began after 24 months of benefits, an employee could continue receiving benefits only if she demonstrated that she was unable to perform "*any* gainful work" for which she was reasonably qualified. *Ibid.* The plan was both administered and insured by petitioner Metropolitan Life Insurance Company (MetLife), and the plan expressly gave MetLife discretionary authority to interpret its terms and determine entitlement to benefits. J.A. 181a-182a.

Respondent has a history of heart problems. In the early 1980s, she developed hypertension; in 1989, she experienced sudden cardiac death, was resuscitated, and was implanted with a defibrillator; and in the 1990s, she was diagnosed with left ventricular dysfunction and hospitalized twice. Pet. App. 4a. In 2000, her treating cardiologist, Dr. Rajendera Patel, diagnosed her with severe dilated cardiomyopathy, a condition in which the heart does not pump properly. *Id.* at 2a-3a; J.A. 89a-91a. Dr. Patel advised that respondent could not continue working at any job that entails "any significant physical or psychological stress." J.A. 82a. As a Sears sales manager, respondent supervised 20-30 employees, was required to stand or walk for most of the work day, and reported directly to the store's general manager. Pet. App. 2a-3a; J.A. 115a-117a.

Respondent stopped working and applied for disability benefits under the Sears plan. Pet. App. 3a. She

submitted a letter from Dr. Patel stating that she "has significant difficulty with general fatigue and exertional shortness of breath because of her cardiac condition" and "cannot return to any kind of job that would require any significant physical or psychologic demands on her." J.A. 88a. According to Dr. Patel, respondent's "main problem" was "the stress at work" that aggravated her cardiac condition. *Id.* at 82a. Dr. Patel also indicated, on a "statement of functional capacity" form provided by MetLife, that respondent was "totally disabled" with respect to her current occupation and "never" would be able to engage in any occupation. *Id.* at 109a-110a.

MetLife approved respondent's claim and began paying benefits. Pet. App. 3a. MetLife directed respondent to apply for Social Security disability benefits and referred her to a law firm to assist her in that process. *Ibid.* A Social Security Administration (SSA) administrative law judge determined that respondent was unable to perform her prior job or any job existing in significant numbers in the national economy and retroactively awarded her disability benefits. *Id.* at 46a-49a. MetLife reduced respondent's benefits and required her to reimburse it for past benefits. *Id.* at 3a-4a.

After paying benefits for 24 months, MetLife notified respondent that she could continue receiving benefits only if she was unable to perform "any gainful occupation." Pet. App. 3a-4a. Respondent submitted additional medical records, including a letter from Dr. Patel dated July 28, 2000, which stated that she still experienced "periods where she feels extremely tired and fatigued," despite some improvement "from the reduction of stress and strain of work." J.A. 84a-85a. In November 2000, June 2001, and December 2001, Dr. Patel completed statements of functional capacity for MetLife,

each time indicating that respondent was "totally disabled" and was "never" expected to resume work activities. *Id.* at 66a-70a, 77a-81a, 95a-99a.

In November 2001, Dr. Patel stated that respondent was "clinically stable," but he noted that she "still gets fatigued out and short of breath, particularly if she is under any kind of significant psychologic stress." Pet. App. 5a; J.A. 62a-63a. In March 2002, in a response to a request from MetLife, Dr. Patel checked a box on a form indicating that respondent "is able to work in a sedentary physical exertion level occupation." Pet. App. 5a-6a; J.A. 57a-58a. In a letter dated June 18, 2002, however, Dr. Patel stated that he "d[id] not believe that [respondent] will handle any kind of stress well at work" and concluded that she is disabled. Pet. App. 6a; J.A. 46a-47a.

MetLife reviewed these records and decided to cease paying benefits on the ground that respondent could perform sedentary work. J.A. 14a-15a. Respondent sought reconsideration. *Id.* at 35a. She submitted a July 2002 letter from Dr. Patel, which reiterated that he "d[id] not believe that [respondent] should be forced to return to any kind of even sedentary work particularly because it is the psychologic stress of work that really exacerbates her cardiovascular condition and symptomology." *Id.* at 44a-45a.

Nonetheless, in August 2002, MetLife denied respondent's disability claim, stating that "[t]here is no supportive medical documentation of the exacerbation of [her] condition and symptomology, due to subjective complaints of work-related stress." Pet. App. 7a; J.A. 29a-33a.

Respondent appealed the benefit denial and submitted an additional letter from Dr. Patel. Pet. App. 7a;

J.A. 41a-43a. In that letter, Dr. Patel reviewed respondent's medical history, explained that she cannot work because "[s]he has a cardiac problem that is exacerbated by any kind of stress," and again concluded that she is "completely disabled." Pet. App. 7a; J.A. 42a. Dr. Patel stated that, although "[p]revious reports filled out by me state that [respondent] was fit for sedentary work, * * * based on her clinical condition and her symptomology, there was never a time where I felt that [she] would be able to return to full-time employment." *Ibid.*

MetLife referred respondent's case to an independent physician, Dr. Chandrakant Pujara, who reviewed respondent's file but did not examine her. Pet. App. 8a; J.A. 37a-40a. Dr. Pujara stated that "[t]he actual impact of any form of real or perceived emotional stress on cardiac arrhytmias, or cardiomyopathy is difficult to gauge," but suggested that respondent "try one of the [recommended] sedentary job classes at least on a trial basis." Pet. App. 8a; J.A. 39a.[1] "If the job environment entails [a] significant degree of emotional stress," he concluded, "then certainly permanent disability can be considered." Pet. App. 8a; J.A. 39a.

MetLife issued a final denial of benefits. Pet. App. 8a; J.A. 23a-26a. It noted that Dr. Patel's June 2002 physical capacity evaluation stated that respondent "could sit for 8 hours, stand for 4 hours, and walk from 2-4 hours in an 8-hour workday" as long as there was "no emotional stress or heavy exertion"; that a certified rehabilitation counselor identified sedentary occupations

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[1] MetLife later acknowledged that respondent "had not been offered a part-time position at Sears" and "would have no chance of receiving benefits under the Sears ERISA plan if she went to work * * * for another employer on the trial basis that Dr. Pujara suggested." Pet. App. 18a n.2.

that respondent could perform consistent with those limitations; and that Dr. Pujara found respondent to be "relatively stable." J.A. 24a-25a. It also noted—but did not respond to—Dr. Patel's February 2003 statement that he "never felt that [respondent] could return to full-time employment." *Id.* at 25a. MetLife concluded, without further elaboration, that "the documentation currently in the file does not support a disability that would prevent [respondent] from performing any occupation." *Id.* at 25a-26a.

3. Respondent filed suit under 29 U.S.C. 1132(a)(1)(B), and the district court upheld MetLife's benefit denial. Pet. App. 27a-40a. The court applied an "arbitrary and capricious" standard of review because the plan "grant[ed] the administrator discretionary authority" to determine benefits. *Id.* at 32a-33a. However, because MetLife "both decides whether an employee is eligible for benefits and pays those benefits," the court concluded that "an actual conflict of interest exists" that "must be "weighed as a 'facto[r]'" in reviewing the benefit denial. *Id.* at 32a-34a (quoting *Firestone*, 489 U.S. at 115).

The district court then reviewed the medical evidence. Pet. App. 38a-40a. Relying on the March 2002 form in which Dr. Patel checked a box indicating that respondent was able to work and on Dr. Pujara's report, the court concluded that there was "substantial evidence supporting MetLife's determination that [respondent] was no longer totally disabled." *Id.* at 37a-40a. The court noted that MetLife had not considered the award of Social Security disability benefits, but it rejected respondent's contention that the award substantiated her disability. *Id.* at 36a.

4. The court of appeals reversed and reinstated respondent's benefits. Pet. App. 1a-26a. Like the district court, it utilized "arbitrary and capricious" review because the plan granted MetLife discretionary authority to determine benefits. *Id.* at 9a. The court held, however, that MetLife was operating under an "apparent conflict of interest" because it was "authorized both to decide whether an employee is eligible for benefits and to pay those benefits," and it concluded that the district court failed to give that conflict "appropriate consideration." *Id.* at 10a.

The court of appeals also determined that the district court gave "inadequate consideration" to MetLife's failure to address the award of Social Security disability benefits, particularly in light of the fact that MetLife "had encouraged and assisted [respondent] in obtaining Social Security disability benefits" and "benefitted financially from the government's determination that [respondent] was totally disabled." Pet. App. 10a, 14a-15a. The court noted that although the Social Security award "certainly [was] not binding," it was "far from meaningless," and MetLife's failure to even consider it is "a significant factor to be considered upon review." *Id.* at 15a (internal quotation marks omitted).

The court of appeals then reviewed the medical evidence, noting MetLife's "persistent failure to give any weight to Dr. Patel's letters of July 22, 2002, and February 12, 2003, in which he clearly stated that he did not believe [respondent] was capable of returning to work, sedentary or otherwise." Pet. App. 15a-16a. Instead, it placed "heavy reliance" on the "aberrational" March 2002 form in which Dr. Patel checked a box suggesting respondent could work. *Ibid.* The court explained that, although MetLife was not required to "accord special

deference to the opinion of [respondent's] treating physician," "it may not arbitrarily repudiate or refuse to consider" it. *Id.* at 19a. The court also noted MetLife's reliance on the opinion of Dr. Pujara, who did not examine respondent and did not appear to have considered Dr. Patel's key reports. *Id.* at 18a-19a. Finally, it noted that MetLife ignored the "consistent and repeated references by Dr. Patel to stress as a factor in [respondent's] condition," in concluding without explanation that "no supportive medical documentation" indicates that stress exacerbates respondent's condition. *Id.* at 21a-22a.

The court of appeals concluded that MetLife's "inappropriately selective consideration of [respondent's] medical record," combined with its conflict of interest and its failure even to acknowledge the Social Security disability benefits award, led to a benefit denial that "can only be described as arbitrary and capricious." Pet. App. 25a.

SUMMARY OF ARGUMENT

As this Court recognized in *Firestone*, Congress did not specify a standard of review when it authorized federal courts to review claims for benefits in 29 U.S.C. 1132(a)(1)(B). As a result, the Court turned to principles of trust law and concluded that courts should review benefit determinations *de novo*, except in the case of an ERISA plan that confers discretion upon the plan administrator to interpret plan terms and make benefit determinations, in which case abuse-of-discretion review applies. In the case of a plan administrator that is entrusted to make discretionary determinations but is operating under a conflict of interest, the Court suggested that the conflict is to be "weighed as a factor" in review-

ing the benefit determination for an abuse of discretion. This case presents that set of facts, because MetLife is a plan administrator that has discretion to make benefit determinations under the terms of the Sears ERISA plan and is required to pay any claims it finds have merit.

An ERISA plan administrator that both makes benefit determinations and pays benefits out of its own funds, such as MetLife, is operating under a conflict of interest, because it benefits financially if it denies an employee's claim. That common-sense understanding of what constitutes a conflict of interest is supported by numerous examples from the law of trusts and is consistent with this Court's recognition of the competing pressures on dual-role administrators in *Firestone*. Rather than seriously dispute the existence of a conflict of interest, MetLife proffers numerous reasons why courts should turn a blind eye to the administrator's self-interest in reviewing benefit determinations. None is persuasive. A court reviewing a benefit determination by a dual-role administrator should consider the administrator's conflict of interest, even in the absence of evidence indicating that the administrator was motivated by its financial self-interest.

Further, as this Court recognized in *Firestone*, a court reviewing a benefit determination by a dual-role administrator should weigh the conflict of interest as a factor in abuse-of-discretion review. That is to say, a court should take extra care to ensure that the plan administrator's decision was reasonable, taking into account all of the relevant facts and circumstances, including the conflict of interest. That standard of review, which derives from trust law, provides the proper balance between an employer's right to set up an ERISA

plan as it sees fit and a participant or beneficiary's entitlement to an impartial benefit determination. Moreover, that context-specific standard provides courts with the needed flexibility to satisfy themselves that a plan administrator's conflict of interest did not lead to an improper denial of benefits.

The Sixth Circuit thus correctly held that MetLife's dual roles as an administrator and insurer of benefits created a conflict of interest that should be taken into account in a review of its benefit denial. Moreover, the Sixth Circuit correctly weighed all of the relevant circumstances under abuse-of-discretion review to conclude that MetLife's benefit denial was unreasonable.

ARGUMENT

AN ERISA PLAN ADMINISTRATOR THAT BOTH PAYS CLAIMS AND MAKES BENEFIT DETERMINATIONS IS OPERATING UNDER A CONFLICT OF INTEREST THAT SHOULD BE WEIGHED AS A FACTOR IN DETERMINING THE REASONABLENESS OF A BENEFIT DETERMINATION

A. An Administrator's Dual Role Constitutes A Conflict Of Interest That Should Be Taken Into Account In A Suit For Benefits

1. A plan administrator that both decides claims and pays benefits from its own funds (*i.e.*, a dual-role administrator) has a conflict of interest under the plain meaning of that phrase. A "conflict of interest" is a "real or seeming incompatibility between one's private interests and one's public or fiduciary duties." *Black's Law Dictionary* 319 (8th ed. 2004). In the ERISA context, a dual-role plan administrator operates under a conflict of interest because it has fiduciary duties to plan participants and beneficiaries to pay meritorious claims, 29 U.S.C. 1104(a)(1)(A) and (B), while having a private

profit-making interest that is furthered by denying claims. See, *e.g.*, *Killian* v. *Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (6th Cir. 1998) (dual-role plan administrator "incurs a direct expense as a result of the allowance of benefits," and "benefits directly from the denial or discontinuation of benefits"); *McGraw* v. *Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1259 (10th Cir. 1998) (for a dual-role administrator, "every exercise of discretion impacts [the administrator] financially, filling or depleting its coffers"). Particularly in "the insurance-company-as-funder-and-administrator context, the fund from which monies are paid is the same fund from which the insurance company reaps its profits." *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000).

Trust law likewise recognizes that a trustee has a conflict of interest when its own financial interests have the potential to conflict with the interests of trust beneficiaries. For example, when a trustee is also "a beneficiary of the trust," "a certain conflict of interest undeniably results." See, *e.g.*, *Gregory* v. *Moose*, 590 S.W.2d 665, 670 (Ark. Ct. App. 1979). Similarly, a "trustee occupies a conflict-of-interest position * * * where he is or may be a successor or remainderman of a substantial portion of the trust estate, particularly where his actions preserve or enhance the value of the succession." *Dowdy* v. *Jordan*, 196 S.E.2d 160, 164 (Ga. Ct. App. 1973). In those situations, there may be a question as to whether that conflict of interest actually influenced the trustee's decisionmaking, but it cannot be denied that a conflict exists. See, *e.g.*, George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 543, at 244-245 (rev. 2d ed. 1993) (when a trustee "has an interest which conflicts with that of the trust beneficiaries," he

"cannot prevent the existence of the conflict of interest," but he may be able to minimize its impact or remove it).

There can be no serious dispute on this point. Although some courts have declined to weigh a dual-role administrator's conflict of interest as a factor in judicial review of a benefit determination, they typically have not denied the *existence* of the administrator's competing interest. Rather, they have determined that the conflict should not be given weight because, in their view, there are countervailing factors that prevent the administrator from acting in its own interest. See, *e.g.*, *Pari-Fasano* v. *ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 418 (1st Cir. 2000) ("an insurer does have a conflict of sorts when a finding of eligibility means that the insurer will have to pay benefits out of its own pocket"). Petitioners, too, do not deny the *fact* of the conflict of interest; they instead argue that it should not be given weight on judicial review. Pet. Br. 21-40. But petitioners' view is inconsistent with the trust law principles that guide interpretation of ERISA.

2. As this Court recognized in *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 109 (1989), although Congress authorized ERISA participants and beneficiaries to sue to recover benefits under the plan, it "d[id] not set out the appropriate standard of review for [such] actions." Because "ERISA abounds with the language and terminology of trust law," the Court determined that it should be "guided by principles of trust law" in "determining the appropriate standard of review." *Id.* at 110-111; see *Central States, Se. & Sw. Areas Pension Fund* v. *Central Transp., Inc.*, 472 U.S. 559, 570 (1985). Trust law counsels that a dual-role plan administrator operates under a conflict of interest that reviewing courts should not ignore.

a. Under settled principles of trust law, courts routinely consider a trustee's conflict of interest in reviewing the propriety of his decisions. As an initial matter, trust law to a significant extent restricts self-interested parties, such as the beneficiaries of a trust, from even being appointed as trustees. Trust law places an exacting duty of loyalty upon a trustee: the trustee must "administer the trust solely in the interest of the beneficiaries," and "is strictly prohibited from engaging in transactions that involve self-dealing or that otherwise involve or create a conflict between the trustee's fiduciary duties and personal interests." Restatement (Third) of Trusts § 78(1) and (2) at 93-94 (2007) (Third Restatement).

If a settlor chooses to appoint a self-interested person as a trustee, however, "the existence of conflicting interests is not ordinarily" a sufficient basis for a court to refuse to honor that choice. Third Restatement § 32 cmt b at 104. Yet courts do not ignore the trustee's resulting conflict of interest. Instead, "when a beneficiary serves as trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*," even in the absence of evidence that the trustee acted in his own self-interest. *Id.* § 37 cmt. f(1) at 137 (emphasis added).

Courts have routinely applied the principle that a trustee's financial self-interest must be considered upon judicial review of his conduct. See, *e.g.*, *Garvey* v. *Garvey*, 22 N.E. 889, 890 (Mass. 1889) (review of actions of trustee who was also remainderman must consider "the influence of a pecuniary interest to withhold from plaintiff any benefit or assistance from said trust"); *In re Peabody's Will*, 96 N.Y.S.2d 556, 562 (Sup. Ct.), aff'd,

98 N.Y.S.2d 614 (App. Div. 1950) (when trustee is also beneficiary and remainderman, his "conduct * * * in the administration of the trust will be subject to careful scrutiny"). Courts do not require evidence that the trustee actually acted with improper motive before considering his conflict of interest. See, *e.g.*, *Fulton Nat'l Bank* v. *Tate*, 363 F.2d 562, 571 (5th Cir. 1966) ("the beneficiary need only show that the fiduciary allowed himself to be placed in a position where his personal interest might conflict with the interest of the beneficiary"; "[i]t is unnecessary to show that the fiduciary succumbed to this temptation").

b. In the ERISA context, as in trust law, a dual-role plan administrator's conflict of interest is a factor that should be considered upon judicial review of its benefit decision. ERISA, like traditional trust law, imposes strict fiduciary duties of loyalty, prudence, and care on plan administrators. 29 U.S.C. 1104(a)(1)(A) and (B). Those duties cannot be waived. 29 U.S.C. 1110(a); see, *e.g.*, *Central States*, 472 U.S. at 568 ("trust documents cannot excuse trustees from their duties under ERISA").

Further, in ERISA, as in trust law, plan administrators may operate under certain conflicts of interest. In particular, a plan administrator may both decide benefit claims and pay those claims. See 29 U.S.C. 1102(c), 1108(c)(3). But that explicit authorization highlights the fact that it is a departure from general trust-law principles to permit an entity with such a conflict to serve as trustee.

Because ERISA incorporates key features of the law of trusts—including a trustee's fiduciary duties and the principle that conflicted fiduciaries may serve only in limited, expressly authorized circumstances—courts

should review a dual-role ERISA plan administrator's decision as they would review the decision of a self-interested trustee. When a plan administrator both makes benefit determinations and pays any benefits due, the administrator's benefit determinations should be subject to "careful scrutiny," even in the absence of specific evidence indicating that the administrator was influenced by its financial interest in the particular instance. Third Restatement § 37 cmt. f(1) at 137.

Indeed, trust law contemplates a situation similar to that of a dual-role ERISA plan administrator. The Second Restatement of Trusts addresses the example of a trustee who must pay "the income and so much of the principal as in his discretion shall be necessary for the support and comfort" of the beneficiary and then will obtain whatever property is remaining upon the beneficiary's death. § 107 cmt. f, illus. 1 at 237. That trustee, the Second Restatement explains, has a "conflicting interest" that requires his conduct to "be subject to careful scrutiny" when a court considers whether he failed to pay sufficient funds to the beneficiary. *Id.* at 236-237. The same should be true under ERISA: because a plan administrator is better off financially when it does not pay benefits, a court reviewing its benefit decisions should be cognizant of the administrator's financial self-interest. To require a court to do otherwise, as petitioners propose, would be to require it to turn a blind eye to a conflict that indisputably exists, and would undermine the integrity of the ERISA regulatory regime.

c. Consideration of a dual-role administrator's financial self-interest even without specific evidence suggesting the conflict influenced benefit decisions also comports with common sense, because "[a] conflicted fiduciary may favor, consciously *or unconsciously*, its inter-

ests over the interests of the plan beneficiaries." *Brown* v. *Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990) (emphasis added). Moreover, the perception that self-interest could creep into the benefit determination process even in subtle ways can undermine confidence in the fairness of the decisionmaking. Applying an added degree of scrutiny to such decisions is an effective counterweight that can enhance confidence in the integrity of the system.

Moreover, such a rule best comports with ERISA's purposes of "promot[ing] the interests of employees and their beneficiaries in employee benefit plans," *Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983), "protect[ing] contractually defined benefits," *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985), and "providing for appropriate remedies, sanctions, and ready access to the Federal courts," 29 U.S.C. 1001(b). Congress imposed strict standards of loyalty and care to "specifically insulate the trust from the employer's interest." *NLRB* v. *Amax Coal Co.*, 453 U.S. 322, 333 (1981); see 29 U.S.C. 1104(a). "Congress intended in particular to prevent trustees 'from engaging in actions where there would be a conflict of interest with the fund.'" *Amax Coal Co.*, 453 U.S. at 333-334 (quoting S. Rep. No. 383, 93d Cong., 1st Sess. 31-32 (1973)). When an insurer or other plan administrator is nevertheless permitted to engage in such actions, courts should carefully scrutinize them to guard against the possibility that the administrator acted in its own self-interest to deny benefits improperly.

d. The result dictated by trust law and the purposes of ERISA has been foreshadowed by several of this Court's decisions. In *Firestone*, this Court noted that additional scrutiny is warranted in the case of a con-

flicted fiduciary: while "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers," 489 U.S. at 111, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion,'" *id.* at 115 (citing Second Restatement § 187 cmt. d).

This Court has reiterated its concern about the impartiality of dual-role administrators in two recent cases. In *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), the Court considered whether medical treatment decisions made by physicians in a health maintenance organization are fiduciary acts under ERISA. *Id.* at 214. In concluding that they are not, the Court recognized that, where a true fiduciary has a financial stake in the claims decision, "fiduciary capacity [i]s necessarily compromised." *Id.* at 227. More recently, in *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355 (2002), this Court found that a state statute regulating health maintenance organizations was not preempted by ERISA. *Id.* at 364-385. In reaching that conclusion, the Court stated its expectation that review of an administrator's benefit decision "for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised." *Id.* at 384 n.15. This case squarely presents the situation anticipated by the Court, and the Court should hold, consistent with its previous decisions, that a dual-role administrator operates under a conflict of interest that must be considered upon judicial review of a benefit determination.

3. Petitioners proffer several reasons why a court reviewing a benefit decision should ignore a dual-role administrator's conflict of interest. None is persuasive.

a. Contrary to petitioners' contention (Br. 21-23), the text of ERISA does not resolve the matter. Although ERISA permits plan funders to serve as claims administrators, see 29 U.S.C. 1102(c), 1108(c)(3), that authorization does not preclude an appropriately searching review of those administrators' decisions, for Congress left to the federal courts (guided by principles of trust law) the question of how they are to review administrators' decisions, including decisions by dual-role administrators. See *Firestone*, 489 U.S. 108-111; see also *Rush Prudential HMO*, 536 U.S. at 384-386. In fact, to the extent ERISA speaks to the issue, it suggests that a conflicted plan administrator's decisions should be carefully scrutinized, rather than insulated from meaningful judicial review, because ERISA imposes exacting fiduciary duties upon plan administrators and permits certain conflicts of interest only as exceptions to a general rule that such conflicts are not permitted. See pp. 15-16, *supra*; see also *Russell*, 473 U.S. at 142-143 (noting that "the avoidance of conflicts of interest" is among the primary statutory duties imposed by ERISA on fiduciaries).

b. Petitioners are likewise incorrect in contending (Br. 26-27) that courts should ignore a dual-role administrator's financial self-interest because a reviewing court's mere consideration of that factor would increase litigation. That contention is debatable as a matter of theory and lacks any empirical support. It also ignores Congress's overriding desire to protect plan participants and beneficiaries from self-interested fiduciaries. See p. 17, *supra*. Indeed, the *Firestone* Court rejected the argument petitioners now make, explaining that "the threat of increased litigation is not sufficient" to abandon the default *de novo* standard of review, which is

most consistent with settled principles of trust law and with ERISA's purposes. 489 U.S. at 114-115.

c. Petitioners also contend (Br. 29-33) that "the practical realties of the insurance business impose significant checks" upon them. There is no doubt some truth to this point, and it presumably explains Congress's willingness to countenance the conflict of interest in the first place. But it is not a basis for wholly ignoring the administrator's self-interest. And to the extent there are specific reasons to doubt that a conflict had any effect in a particular case, a court is free to consider such factors in its review for reasonableness. See p. 28, *infra*.

First, petitioners argue (Br. 29-30) that insurance companies have "reputational incentives" that will counteract their inherent conflict of interest. But while that is true, insurance companies' "reputational incentives" run in more than one direction, as they have incentives to keep costs down so that they can offer attractive rates to companies. See, *e.g.*, *Pinto*, 214 F.3d at 388 ("insurance carriers have an active incentive to deny close claims in order to keep costs down and keep themselves competitive so that companies will choose them as their insurers"). Moreover, there are limits to how much information employees will have and thus limits on the "reputational incentives" vis-a-vis employees. "Employees typically do not have access to information about claim-denying by insurance companies," especially because "many claims for benefits are made after individuals have left active employment." *Ibid.*

Second, petitioners contend (Br. 31-32) that an administrator's "employees who actually make benefit determinations do not have direct personal stakes in the outcome of their decisions." See BCBS Br. 14-15. The fact that there may be several layers in the principal-agent

relationship may distinguish the classic context of a single trustee with a conflict of interest, but it does not eliminate the conflict. It seems unrealistic that employees of the administrator would ignore the financial interests of their principal altogether. And courts and commentators have compiled ample evidence that insurance companies have reinforced that natural tendency by giving employees incentives to deny claims. See, *e.g.*, *Armstrong* v. *Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997) ("Apparently to limit claim payments, Aetna provides incentives and bonuses to its claims reviewers based on criteria that include a category called 'claims savings.'"); John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315, 1317-1321 (2007) (giving numerous examples of Unum/Provident's "cost containment measures that pressured claims-processing employees to deny valid claims"). Petitioners are also mistaken in comparing (Br. 31-33) the incentives of insurance company claims administrators to those of federal administrative law judges or prosecutors, most obviously because the federal government itself, unlike an insurance company, is not a for-profit institution. Cf. *Schweiker* v. *McClure*, 456 U.S. 188, 196-197 (1982).

Petitioners' amici argue (ACLI Br. 6; BCBS Br. 11-12) that any one individual claim has a minimal impact on the annual operating budget of a large insurance company such as petitioner. But increases in scale do not eliminate conflicts of interest. Because profits are made from claims decisions in the aggregate, "[o]ver time, a predilection to deny coverage pays well, even for inexpensive and infrequent treatments." *Carolina Care*

Plan, Inc. v. *McKenzie*, 467 F.3d 383, 387 (4th Cir. 2006).

Finally, petitioners argue (Br. 34-39) that federal and state regulators will adequately protect plan participants and beneficiaries. That contention cannot be squared with Congress's decision to provide, in *addition* to state and federal regulation, a civil cause of action for a participant or beneficiary to sue "to recover benefits due to him under the terms of his plan," 29 U.S.C. 1132(a)(1)(B). Although the Secretary of Labor has the authority to enforce fiduciary duties, see Pet. Br. 38-39, *only* a participant or beneficiary may bring a claim for benefits under 29 U.S.C. 1132(a)(1)(B), which makes the courts' role even more important in ensuring that administrators pay benefits due. Moreover, the extensive regulation of insurance companies by States is premised on the judgment that *increased* scrutiny generally is required "to prevent abusive practices—for example, false sales illustrations or failure to pay legitimate claims on a timely basis—that take unfair advantage of consumers." Robert W. Klein, *Insurance Regulation in Transition*, 62 J. Risk & Ins. 373, 374 (1995); see Langbein, *supra*, at 1340 (detailing such practices by Unum/Provident). There is thus ample reason for courts to acknowledge and weigh a dual-role administrator's conflict of interest.

B. A Benefit Denial By A Dual-Role Administrator That Has Been Granted Discretionary Authority To Determine Benefit Claims Should Be Reviewed For Reasonableness Under The Totality Of The Circumstances

1. Under settled principles of trust law, a court reviewing a discretionary decision of a self-interested trustee considers the conflict of interest as one factor in

determining whether the trustee's decision was reasonable. Some trustee powers and duties are "mandatory," in that they are "directed by the terms of the trust or compelled by the trustee's fiduciary duties," and others are "discretionary," meaning that the trustee "is to use fiduciary judgment." Third Restatement § 87 cmt. a at 242. When "discretion is conferred upon" a trustee "with respect to the exercise of a power," its exercise is subject to review for "an abuse * * * of his discretion." Second Restatement § 187 & cmt. d at 402-403; see Third Restatement § 87 & cmt. b at 242-243. In applying abuse-of-discretion review, courts apply "'a general standard of reasonableness,'" where "judicial intervention on the ground of abuse is called for, not because the court would have exercised the discretion differently, but because the trustee's decision is one that would not be accepted as reasonable by persons of prudence." Third Restatement § 87 cmt. c at 244-245.

In assessing the reasonableness of the trustee's decision—whether in interpreting the relevant instruments, making factual determinations, or exercising judgment in other respects—one relevant factor is "the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries." Second Restatement § 187 & cmt. d at 402-403; see 3 Austin W. Scott & William F. Fratcher, *The Law of Trusts* § 187 at 15 (4th ed. 1988) (same). When a "conflict-of-interest situation[] exist[s], the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." Third Restatement § 37 cmt. f(1) at 137.

2. Utilizing those trust-law principles, this Court in *Firestone* established the basic framework for how a conflict of interest should be taken into account in a suit

for benefits. The Court first concluded that courts should generally review benefit decisions *de novo*. 489 U.S. at 115. But it recognized that ERISA generally permits employers, like settlors under private trust law, to set up plans as they see fit, within the general parameters of the Act, see, *e.g.*, *Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432, 444 (1999), and to grant discretion to plan administrators to interpret plan terms and determine claimants' eligibility for benefits. *Firestone*, 489 U.S. at 115; see 29 U.S.C. 1108(c)(3). ERISA also permits an employer to establish a welfare benefit plan "through the purchase of insurance." 29 U.S.C. 1002(1). A plan sponsor thus could reasonably choose to give discretionary authority for claims administration to an insurance company, notwithstanding its conflict of interest as the ultimate payor of benefits, in light of the cost of alternative arrangements, the insurer's expertise in administering and resolving claims, and the insurance company's past claims history. Where the sponsor has expressly chosen to give the insurer discretion to interpret plan terms or determine eligibility for benefits, review of those decisions applying the abuse-of-discretion standard—under which the decisions "will not be disturbed if reasonable," *Firestone*, 489 U.S. at 111—is the logical starting point because it best comports with the contractual and trust-law underpinnings of ERISA. See *id.* at 110-115; see also Third Restatement § 87 cmt. b at 243 ("A court will not interfere with a trustee's exercise of a discretionary power * * * when that conduct is reasonable.").

At the same time, ERISA mandates that a fiduciary "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries," 29 U.S.C. 1104(a)(1), which incorporates the traditional duty of

loyalty of a trustee, see Third Restatement § 79 at 127. Accordingly, the very principles of trust law that call for review of discretionary decisions under a general standard of reasonableness also counsel that a plan administrator's conflict of interest must be weighed as a factor under that standard, as this Court also recognized in *Firestone*. See 489 U.S. at 115. Specifically, the existence of a conflict of interest requires a reviewing court to take extra care to ensure that the benefit determination was reasonable.

This flexible standard of review best balances ERISA's requirements of fiduciary loyalty, 29 U.S.C. 1104(a)(1), and "full and fair" review of benefit claims, 29 U.S.C. 1133(2); see 29 C.F.R. 2560.503-1(g), (h) and (j), with the statutory authorization for fiduciaries to serve in dual roles, 29 U.S.C. 1108(c)(3), and for employers generally to set up plans as they see fit, including through the purchase of insurance. This approach neither assumes that every administrator with a conflict of interest resolves disputes in a biased manner, nor uncritically defers to the administrator's judgment as if the conflict did not exist. Review under the general standard of reasonableness simply requires that the court's review be as searching of the administrator's decision as the facts and circumstances—including the existence of a conflict of interest—warrant. See *Woo* v. *Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998).

3. Neither more searching review nor more lenient review would be appropriate. Because the discretionary decisions of trustees are reviewed for an abuse of discretion (unreasonableness) even when they operate under conflicts of interest under trust law, see pp. 14-15, *supra*, and because the *Firestone* Court declined to rest its general rule of *de novo* review on the existence of an

underlying conflict of interest, 489 U.S. at 115, *de novo* review should not be required where the plan vests discretionary authority in an administrator that also pays benefits. Rather, the existence and nature of a conflict of interest should be taken into account as *part of* traditional review for reasonableness.

Nor is there any reason to shift the burden of proof to the plan administrator to establish that he was untainted by the conflict. Such an approach lacks any basis in the law of trusts, and it would complicate judicial review unnecessarily by diverting the court's attention away from the ultimate question in the case, which is the overall reasonableness of the plan administrator's benefit decision. See, e.g., *Doyle* v. *Liberty Life Assurance Co.*, 511 F.3d 1336, 1344-1346 (11th Cir. 2008).

At the same time, there is no basis in ERISA or the law of trusts for categorically giving a dual-role administrator's conflict of interest only "*de minimis* weight" (Pet. Br. 41). To do so would be to disregard trust law's concern about conflicted fiduciaries and Congress's intention that courts protect ERISA participants and beneficiaries from self-interested administrators. See pp. 14-17, *supra*.

4. The majority of courts therefore have correctly concluded that "[a]buse of discretion review applies to a discretion-granting plan even if the administrator has a conflict of interest," but that review must be "informed by" the administrator's conflict of interest. *Abatie* v. *Alta Health & Life Ins. Co.*, 458 F.3d 955, 965, 967 (9th Cir. 2006).[2] Under that approach, a court should dis

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[2] Some courts have described this type of review as abuse-of-discretion review on a "sliding scale," while others reject that metaphor but use essentially the same approach. Regardless of whether the sliding scale metaphor is helpful, the United States agrees with the

agree with a plan administrator's decision only if it is unreasonable in light of all of the facts and circumstances. *Pinto*, 214 F.3d at 392 (approach "allows each case to be examined on its facts"). Courts may not overturn a "reasonable claim determination * * * simply because record evidence supports both sides of the issue," Pet. Br. 28, but they should take extra care to ensure that the administrator's determination was reasonable when there are factors that both undermine the objective soundness of the determination and at the same time suggest that the plan administrator might have been influenced by its conflict of interest.

For example, the existence of a conflict of interest should cause a court reviewing for reasonableness to give added scrutiny when an administrator: (1) "provides inconsistent reasons for [the benefit] denial," *Abatie*, 458 F.3d at 968-969; (2) "fails adequately to investigate a claim or ask the plaintiff for necessary evidence," *ibid.*; (3) "fails to credit a claimant's reliable evidence," *ibid.*; (4) "has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record, *ibid.*; (5) "revers[es] its own initial determination" that the claimant qualified for benefits, *Pinto*, 214 F.3d at 393-394; (6) reviews the claimant's evidence with "a selectivity that appears self-serving," by, for example, "credit[ing] one part of the advice of a treating doctor, but not his other advice," *ibid.*; or (7) intervenes on the claimant's behalf in administrative appeals to obtain finding of disability, then concludes

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approach of the majority of courts, which accounts for the structural conflict inherent in dual-role administration by giving a close look to the reasonableness of a conflicted administrator's decision in light of the process, rationale, and underlying evidence. See pp. 26-31, *supra*.

she is not disabled, *Ladd* v. *ITT Corp*, 148 F.3d 753, 755-756 (7th Cir. 1998). The court could also consider the "financial arrangement between the insurer and the company." *Pinto*, 214 F.3d at 392.

In addition, concern would be raised if there is evidence suggesting that the administrator denied the claimant full and fair review of his claim, as guaranteed by statute and by the Department of Labor's claims regulations, see 29 U.S.C. 1133(2); 29 C.F.R. 2560.503-1(g), (h) and (j), although such a defect may well constitute an independent ground for setting aside an administrator's decision. See *Abatie*, 458 F.3d at 972-973. Further, an administrator, facing closer scrutiny, might find it advisable to demonstrate that it has taken measures to mitigate conflict concerns, through the use of truly independent medical examiners or by ensuring that its claims reviewers do not have incentives to deny claims. See *id.* at 969 & n.7.

Moreover, the increased scrutiny cannot lose sight of the source of the conflict of interest. The point is not that dual-role administrators are generally less capable of making benefit determinations, but that there are potential financial incentives to skew decisions. Accordingly, in a dispute about benefits where the two alternative differ in respects other than costs (such as determining which of two individuals is the beneficiary under a life insurance policy), a financial conflict of interest would not be a relevant factor. Conversely, in a case like this involving a permanent disability determination, the significant dollar value of the benefit stream over time makes more focused review appropriate.

Under the proper approach, reviewing courts may take extra care to satisfy themselves that an inherent conflict of interest does not affect a benefit determina-

tion, without being required to undertake *de novo* review or burden-shifting. See *Chambers* v. *Family Health Plan Corp.*, 100 F.3d 818, 827 (10th Cir. 1996). Indeed, reasonableness review that permits courts to take a close look at benefit determinations is especially appropriate here, to permit the full "consideration of unique factors that are little susceptible * * * of useful generalization," *Cooter & Gell* v. *Hartmarx Corp.*, 496 U.S. 384, 404 (1990) (internal quotation marks omitted), such as the various factors identified above that both diminish the objective persuasiveness of the administrator's decision in its own right and at the same time could reflect a departure from the care, prudence, and rigorous attention to the duty of loyalty to participants and beneficiaries that are necessary to avoid decisions that are based upon the plan administrator's self-interest. In this context, as in many others, "[t]he deference that is due depends on the nature of the question presented," *Koon* v. *United States*, 518 U.S. 81, 98 (1996), and the tailored abuse-of-discretion review utilized by the majority of circuits provides the best way to "weigh" a conflict of interest in review of a benefit determination. See *Abatie*, 458 F.3d at 969 ("trial courts are familiar with the process of weighing a conflict of interest"). And any effort to articulate more precise standards or rules would likely prove to be unhelpful and even counterproductive, by introducing rigidity or artificiality into a process that ultimately calls for the exercise of sound judicial judgment of the sort that courts of equity traditionally have exercised in trust cases.[3]

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[3] Some courts have equated abuse-of-discretion review and "arbitrary and capricious" review and held, under the latter, that the court need only be satisfied that "substantial evidence" supports the plan administrator's decision. *E.g.*, *Wright* v. *R.R. Donnelley & Sons*

A plan's delegation of discretionary authority to interpret plan terms or decide coverage or eligibility questions is not a license to deny in practice what the plan promises in principle. Even when operating under a grant of discretion, the decisionmaker at each level of administrative review owes the participant an impartial determination guided by the terms of the plan as applied to the facts presented and the Secretary's claims pro-

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Co. Group Benefits Plan, 402 F.3d 67, 73-74 & n.3 (1st Cir. 2005). In the administrative law context, the "substantial evidence" standard for reviewing agency factual findings is even more deferential than the "clearly erroneous" standard of appellate review, *Dickinson* v. *Zurko*, 527 U.S. 150, 164 (1999), and it is satisfied if the evidence would justify, in a jury trial, a refusal to take a decision away from the jury, *id.* at 162; *NLRB* v. *Columbian Enameling & Stamping* Co., 306 U.S. 292, 300 (1939). And the "arbitrary and capricious" standard more generally requires only a "rational" foundation for the agency decision. See *Motor Vehicle Mfgrs. Ass'n* v. *State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42-43 (1983). Those standards are specifically identified in the Administrative Procedure Act itself, 5 U.S.C. 706(2)(A) and (E), and they reflect a special measure of deference rooted in the separation of powers and statutory allocations of governmental power. See, *e.g.*, *FCC* v. *Pottsville Broadcasting Co.*, 309 U.S. 134, 141 (1940).

ERISA's statutory cause of action to recover benefits under a plan does not incorporate those standards. It rather looks to the distinct body of private trust law, which imposes special fiduciary duties of loyalty, prudence, and care and assigns reviewing responsibilities to courts under a more general standard of reasonableness that traditionally has required especially careful scrutiny in the case of a self-interested trustee. There are other key differences between ERISA and the administrative law context. "Decisions in the ERISA context involve the interpretation of contractual entitlements; they are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers," and "the individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies." *Brown*, 898 F.2d at 1564 n.7 (internal quotation marks omitted).

cessing regulations. Only under the meaningful yet flexible standard of review for reasonableness can the courts ensure that participants and beneficiaries receive the benefits they are due.

C. The Court Of Appeals Correctly Determined That MetLife Abused Its Discretion In Denying Benefits Here

The court of appeals in this case correctly determined that MetLife operated under a conflict of interest that should be weighed in reviewing MetLife's benefit determination. Pet. App. 9a-10a, 24a-26a. In addition, the court of appeals applied appropriately searching judicial review to conclude that MetLife abused its discretion in denying respondent's claim for benefits. *Id.* at 9a-10a.

The court of appeals had ample basis to closely scrutinize, and ultimately to overturn, MetLife's benefit denial. In addition to MetLife's inherent conflict of interest (Pet. App. 10a), which was fully implicated by a denial of permanent disability benefits, the court considered numerous other factors, such as MetLife's failure in its final decision to consider the award of Social Security benefits that it helped respondent obtain. *Id.* at 10a-11a, 14a-15a. The SSA determination was plainly relevant because the Social Security standard was more stringent than the plan's definition of disability, *id.* at 13a & n.1, and because respondent's condition remained essentially unchanged from the time of the SSA award to the time of MetLife's denial of benefits, *id.* at 3a-8a. Yet MetLife never even addressed it. *Id.* at 16a. Consistent with *Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822 (2003), the court noted that, although the SSA determination was "certainly not binding," it was

also "far from meaningless." Pet. App. 15a (internal quotation marks omitted).

The court of appeals also noted MetLife's "inappropriately selective" analysis of the medical evidence, Pet. App. 9a-10a, 25a, which included its "persistent failure to give any weight" to the letters in which Dr. Patel "clearly stated that he did not believe [respondent] was capable of returning to work," *id.* at 15a. Instead, MetLife relied heavily on a two-page form where Dr. Patel checked "yes" to a question regarding whether respondent could work, despite the fact that that response "is so inconsistent with other medical evidence and detailed reports supplied by Dr. Patel over a period of three years that it can best be described as aberrational." *Id.* at 16a. MetLife "offered no explanation for its resolution" of that inconsistency in the evidence; indeed, it was unclear whether MetLife considered Dr. Patel's unequivocal conclusion at all. *Id.* at 20a.

Further, the court noted that MetLife chose to conduct a file review rather than have Dr. Pujara examine respondent and that MetLife apparently did not provide that reviewing doctor (or MetLife's occupational skills analyst) with the letters in which Dr. Patel stated unequivocally that respondent could not return to work. Pet. App. 18a-19a. And it observed that Dr. Pujara's conclusions were equivocal at best: indeed, he stated that "permanent disability can be considered" if respondent's job entails a "significant degree of emotional stress." *Id.* at 8a.

The court also pointed out that, "[d]espite the consistent and repeated references by Dr. Patel to stress as a factor in [respondent's] condition," MetLife concluded that there was "no supportive medical documentation" showing that her condition is exacerbated by stress, and

it provided no explanation for that conclusion. Pet. App. 21a-22a. The court recognized that, under *Nord*, MetLife was not required to "accord special deference" to Dr. Patel as respondent's treating physician, but that does not mean it could "arbitrarily repudiate or refuse to consider [Dr. Patel's] opinions." *Id.* at 19a, 23a-24a; see *Nord*, 538 U.S. at 834. Considering all of those factors, the court of appeals had ample basis on the record before it to conclude that MetLife's denial of benefits was outside the range of reasonableness and that respondent therefore is entitled to recover disability benefits under the plan.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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IN THE SUPREME COURT OF THE UNITED STATES

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,
Petitioners,

v.

WANDA GLENN,
Respondent.

On Writ of Certiorari To The United States Court of Appeals For the Sixth Circuit

BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF RESPONDENT URGING AFFIRMANCE

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INTEREST OF *AMICUS CURIAE*[1]

AARP is a nonpartisan, nonprofit membership organization of nearly 40 million persons age 50 or older, more than half of whom are employed. AARP is dedicated to addressing the needs and interests of older persons. Countless members participate in employer-funded health, pension, disability, and other employee and retiree benefit plans. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all. In its efforts to foster the economic security of individuals as they age, AARP seeks to increase the availability, security, equity, and adequacy of public and private pensions, health, and other employee benefits.[2]

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[1] The parties have consented to the filing of this brief. *Amicus curiae* AARP states that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission.

[2] As part of its advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefit of ERISA's protections, AARP has participated as *amicus curiae* in numerous cases involving the scope of a fiduciary's duties, the appropriate standard of judicial review of plan administrators' benefit eligibility determinations under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and the scope of remedies available under ERISA's civil enforcement provisions. *See, e.g., LaRue v. DeWolff*, Boberg & Assocs., 552 U.S. _, 128 S. Ct. 1020 (2008); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Abatie v. Alta Health*

(continued...)

Given the exclusivity of ERISA's civil enforcement provisions for participants in employee benefit plans, see *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004), it is imperative that participants have meaningful recourse under ERISA to protect and enforce their rights under such plans. The issues in this case directly bear on the standard of review applicable to a benefit denial by a plan administrator. Thus, resolution of the issues in this case will have a significant impact on the integrity of the administration of employee benefit plans and individual participants' abilities to obtain those benefits which will foster their economic security. AARP, therefore, submits its brief amicus curiae to facilitate a full consideration by this Court of these issues.

SUMMARY OF ARGUMENT

An inherent conflict of interest exists when an ERISA benefit plan administrator also funds plan benefits because a plan administrator cannot act in its own financial interest while simultaneously acting in the best interests of plan participants. The recognition of such a conflict is supported by the language and legislative history of the ERISA statute and by age old common law principles founded in trust law and contract law. The text and history of ERISA's civil enforcement provisions also indicate an affirmative mandate that the *de novo* judicial standard of review is applicable in the district courts to participants' challenges to benefit denials by plan administrators operating under a conflict of interest.

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[2](...continued)
& Life Ins. Co., 458 F.3d 955 (9th Cir. 2006) (en banc); *Milofsky v. Am. Airlines*, 442 F.3d 311 (5th Cir. 2006); *In re Schering-Plough ERISA Litig.*, 420 F.3d 231 (3d Cir. 2005); *Callery v. U.S. Life Ins. Co.*, 392 F.3d 401 (10th Cir. 2004); *Steinman v. Hicks*, 352 F.3d 1101 (7th Cir. 2003).

ARGUMENT

I. AN ADMINISTRATOR THAT BOTH EVALUATES AND PAYS CLAIMS UNDER A PLAN GOVERNED BY ERISA IS, WITHOUT MORE, OPERATING UNDER A CONFLICT OF INTEREST THAT MUST BE WEIGHED ON JUDICIAL REVIEW OF A BENEFIT DETERMINATION.

A. ERISA's Statutory Text Compels The Inescapable Conclusion That A Conflict Of Interest Attaches When A Plan Administrator Is Also The Funding Source For Plan Benefits.

Under ERISA § 404(a), 29 U.S.C. § 1104(a), "a fiduciary shall discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and for the *exclusive purpose* of providing benefits to participants and their beneficiaries. . . ." (emphasis added). Plan administrators that also serve as the funding source for benefits have a concurrent and conflicting financial interest in the outcome of their benefit eligibility determinations. Indeed, a majority of the Courts of Appeals have concluded that a plan administrator that also funds plan benefits operates under a conflict of interest that courts must take into account on judicial review. *See Post v. Hartford Ins. Co.*, 501 F.3d 154, 161-64 (3d Cir. 2007); *Carolina Care Plan Inc. v. McKenzie*, 467 F.3d 383, 386-87 (4th Cir. 2006); *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F.3d 287, 295-96 (5th Cir. 1999) (en banc); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-66 (9th Cir. 2004) (en banc); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (10th Cir. 2004); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561, 1566-67 (11th Cir. 1990).

B. The Court's Decisions Recognize A Fundamental, Immutable Principle That A Person Cannot Concurrently Serve Two Masters With Conflicting Interests.

It is natural to view the legal role of a plan administrator under an ERISA plan as that of an agent of the plan, who is bound to conduct itself in accordance with the ERISA imposed duty to fulfill the plan's statutorily required purpose, i.e., to "discharge his duties *solely in the interest of the* [plan's] *participants and beneficiaries* and . . . for the exclusive purpose of . . . *providing benefits to* [plan] *participants and their beneficiaries* . . . . § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A) (emphasis added). Thus, it is no stretch of law or analysis to invoke in the ERISA dual role context the general rule that a person cannot simultaneously serve "two masters with opposed interests." *United States v. Miss. Valley Generating Co.*, 364 U.S. 520, 550 (1961); *see also NLRB v. Town & Country Elec., Inc.*, 516 U.S. 85, 93 (1995).

> Since . . . the relation of master and servant is dependent upon the right of the master to control the conduct of the servant in the performance of the service, giving service to two masters at the same time normally involves a breach of duty by the servant to one or both of them . . . . [A person] cannot be a servant of two masters in doing an act as to which an intent to serve one necessarily excludes an intent to serve the other.

NLRB v. Town & Country Elec., 416 U.S. at 93 (quoting Rest. 2d Agency § 226, Comment *a*, at 449 (1957)). Contrary to the insistence of Petitioners at Page 21 of their brief that Congress made it clear that "it did not consider a fiduciary that is separately responsible for paying the claims that it reviews to be

acting 'in [its] own interest.'" Neither ERISA's statutory text nor any decision of this Court validates Petitioners reading of *Pegram v. Herdrich,* 530 U.S. 211 (2000) (emphasis added). *Pegram* does not support the proposition that the determinations of a benefit plan administrator which evaluates eligibility and also pays benefits escape characterization as conflicted. *Pegram*, after all, was a claim seeking to establish fiduciary liability under ERISA § 409(a), 29 U.S.C. 1109(a), and that case held no more than that mixed decisions by HMO physicians are not fiduciary decisions under ERISA. Petitioners' contention that from *Pegram*'s holding the Court must leap to the conclusion that benefit eligibility decisions by insurance company claims managers on ERISA claims brought under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), are without conflict cannot withstand analysis. *Brief of Petitioners* at 21.

The functional plan administration work of evaluating benefit claims is conducted primarily by benefit claims managers, employees of plan administrators who frequently work pursuant to financial incentive schemes that may reward them for effective denial or termination of claims. To compare their status under ERISA to physicians employed by an HMO that pays year-end bonuses based upon the HMO's profitability performance is to miss the point of *Pegram*'s holding and to ignore the fact that the medical treatment decisions made by the physician at issue in *Pegram* were subject to any number of separate external standards of professional performance as well as to external accountability. In contrast, claims managers have virtually none of either.

External controls over physicians are numerous. For example, all practicing physicians are sworn under the Hippocratic oath to act in the interests of their patients. Moreover, practicing physicians in all jurisdictions are subject to mandatory qualification

and licensure standards as set by their respective practice jurisdictions. Furthermore, physicians are subject to professional performance standards manifest in the standard of care recognized in the respective localities in which they practice, and they are accountable under the respective tort law regimes applicable to them for departures from those standards. No such external regime of performance standards or outside institutional accountability attaches to the decisions of benefits claims managers. To the contrary, ERISA's expansive preemption shield virtually insulates claims managers from any accountability whatsoever in the event of a departure from non-conflicted eligibility decision-making. *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

In light of ERISA § 404(a)'s statutory command to plan administrators of loyalty to the interests of plan participants and beneficiaries, a plan administrator's obligations to participants and beneficiaries, coupled with an administrator's for-profit operating imperative and concurrent responsibilities to its equity holders, casts a classic example of service to one master that requires abandonment of service to the other. The interests of beneficiaries and the funding source are directly antagonistic, as any payment to the beneficiary derives from the plan administrator's financial resources. Furthermore, the prospect of financial incentives for benefits claims managers on account of aggressive and payment-saving performance exacerbates the conflict.

It is no answer to say that every commercial transaction that pits parties at arms length inherently has the same type of tension as the dual role ERISA plan administrator. Here, the plan participant's claim under an ERISA employee benefit plan is not a typical commercial transaction in any sense. In the first place, the plan administrator and the claimant cannot be said to stand at arms length, as the claimant did not negotiate the contract with the plan administrator.

Instead, the relationship is typically governed by a group contract that lays out the terms of the contract including the judicial standard of review and certain claims procedures by which the claimant is bound. The claims procedure in the vast majority of cases creates a permanent, comprehensive record upon which the claim will be decided.

The entirety of the claims process is administered by the plan administrator, who decides what constitutes the record and ultimately makes a determination of eligibility, i.e., decides whether to pay the claim. Lacking from the entire process is any neutral party without a stake in the outcome of the claim. In the event the claimant believes he or she is aggrieved at the conclusion of the administrative process, which includes an administrative appeal (also administered and adjudicated by the plan administrator), then under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), the claimant may challenge the claim administrator's determination by filing an ERISA civil enforcement suit in federal court. In such a challenge the claimant generally may not supplement the substantive record upon which the claim was decided. And in the claimant's civil enforcement proceeding under ERISA, it is typical for the court to review the determination of the plan administrator under an arbitrary and capricious standard, i.e., with a view highly deferential to the plan administrator.

Petitioners point to the absence in ERISA's prohibited transaction rules of any provision making both evaluating and paying benefits a *per se* prohibited transaction as support for the conclusion that no conflict inheres in that dual role status. *Brief of Petitioners* at 21-22. Although the prohibited transaction rules do not specifically bar such dual roles in plan administration, this fact stems in large part from the historical fact that the enactment of ERISA was driven primarily by Congressional concern for the

integrity of retirement pension funding. In that context it was and is plainly foreseeable that employers would act as plan administrators of the same pension benefits that they undertake to fund for their employees, both of those roles being incidental to the employer's primary line of business. That scenario is altogether different in kind from the delegation of plan administration and plan funding by employer sponsored group insurance plans to third parties for health, life, and disability coverages. Dual role plan administrators are frequently insurance companies such as Petitioner MetLife here, whose profit is *primarily* derived from claims administration and benefit funding. In such situations, the plan administrator may well have far less at stake in meeting the reasonable expectations of the employees, who are the participants and beneficiaries of the employer sponsored plans that they administer and fund, than they have to gain from unduly hard-nosed plan administration and parsimonious benefit payment practices. Unlike the employers to whom they sell their services, the very business success of these hired plan administrators may well be driven by their claim evaluation and payment experience. *Amicus* submits that the prohibited transactions provisions were drafted with a view to practicality for the commonplace situation of the employer-plan sponsor rather than with the intention of exonerating third party plan administrators from traditional conflict of interest standards. Clearly, a dual role insurer such as Petitioner MetLife operates under a conflict of interest that a court must consider in reviewing benefit denials.

II. A PARTICIPANT WHO HAS BEEN DENIED BENEFITS UNDER AN ERISA PLAN IS ENTITLED TO *DE NOVO* JUDICIAL REVIEW OF THE BENEFIT ELIGIBILITY DETERMINATION.

Congress enacted ERISA to protect participants' and beneficiaries' interests in employee benefit plans by setting out substantive regulatory requirements, including standards of conduct, responsibility, and obligation for fiduciaries and to provide for appropriate remedies, sanctions, and ready access to the federal courts. ERISA § 2(b), 29 U.S.C. § 1001(b); *Davila*, 542 U.S. at 208; *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 264 (1993).

A. ERISA's Text Contemplates *De Novo* Review Of Benefit Eligibility Determinations.

"The starting point in every case involving construction of a statute is the language itself." *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756 (1975); *Larue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. __, 128 S. Ct. 1020 (2008) (Thomas, J. concurring); *Inter-modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510 (1997). The language of ERISA demonstrates that Congress viewed benefit claims as questions of entitlement to "contractually authorized benefits," *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985), to be reviewed *de novo* by the courts.

Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), provides that a participant or beneficiary may bring a civil action "to recover benefits due to him under the terms of his plan [or] to enforce his rights under the terms of the plan." (emphasis added). The plan itself must be "established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1), which must "specify the basis on

which payments are made . . . from the plan," 29 U.S.C. § 1102(b)(4). These provisions spell out a statutory scheme under which a participant's entitlement to benefits must originate from a written plan–which may be presumed to be a trust instrument or a contract–and under which a participant may bring a civil action to compel payment of such benefits.

In contrast to the provision authorizing a participant to bring a civil action to recover benefits due under a plan, sections 502(a)(2) & (3) authorize civil enforcement proceedings to be brought by named persons to redress fiduciary misconduct. This Court has recently held that actions seeking relief against fiduciaries must be brought on behalf of the plan, even if the ultimate recovery is to inure to a single participant account. *Larue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. __, 128 S. Ct. 1020 (2008). The textual differences of the respective provisions are instructive. Section 502(a)(1)(B) empowers the participant to enforce his rights. The notion of enforcement is inconsistent with an administrative regime of the sort that ties the participant's legal rights to a court's deferential review of a dual role administrator's eligibility determination. A comparison of the language of the respective civil enforcement provisions contemplates an equitable type of action for sections 502(a)(2) & (3), but a distinctly legal type of action and remedy under section 502(a)(1)(B).

Firestone's reliance on principles of trust law in navigating to its holding that *de novo* is the default standard of review for section 502(a)(1)(B) claims appears to be soundly grounded in ERISA's textual language and the avowed Congressional purpose. It is an open question whether the Court deems it prudent to continue to stand by *Firestone*'s embrace of trust law principles for all purposes in sorting out the respective rights of plan participants and plan administrators in ERISA enforcement proceedings.

This is particularly true in determining the appropriate standard of review for actions under section 502(a)(1)(B) when the plan administrator is charged both with evaluating and paying claims.

Firestone, albeit in *dicta*, endorses the principle that all plan administrators are created equal, that impartiality of plan administrators is of no concern, and that the motivations of plan administrators and fiduciaries is irrelevant. Plan administrators have seized upon these dicta in *Firestone* to subvert ERISA's explicit mandate "to promote the interests of employees and their beneficiaries in employee benefit plans," *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983) and to "protect contractually defined benefits," *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. at 148.[3/]

Petitioners' argument that courts should defer to conflicted plan administrators' eligibility determinations is essentially a plea that the industry must be trusted to do the right thing. One need not look beyond simple human nature to recognize that a company whose primary interest is profit-maximization will be tempted to deny meritorious claims in bad faith to avoid profit loss. *See Watson v. UnumProvident Corp.*, 321 F. Supp. 2d 226, 247-48 (D. Mass. 2004) (recognizing a pattern of bad faith denials by a plan adminsitrator that also served as the funding source for benefits); *Brigham v. Sun Life of Can.*, 317 F.3d 72, 85-86 (1st Cir. 2003) (commenting that, under the arbitrary and capricious standard of review, it was bound to affirm the "counterintuitive" but not

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[3/] Petitioner MetLife argues that the realities of the insurance business are that the "long-run reputational incentives for insurance companies to review benefit claims in an equitable manner counteract the purely theoretical short-term interest that a company may have to minimize payouts by denying meritorious claims." *Brief of Petitioners* at 30.

unreasonable decision of the plan adminsitrator to deny benefits); *Prado v. Allied Domecq Spirits & Wine Group Disability Income Policy*, No. C-05-2716, 2008 WL 191985, at *4 (N.D. Cal. Jan. 22, 2008) (holding that the plan administrator's conflict of interest as the fiduciary of the plan and funding source for benefits improperly influenced its decision to deny the claim at issue).

The Unum/Provident scandal provides a distressing example of the mischief that results from allowing plan administrators that also serve as the funding source for benefits to take advantage of a discretionary standard of judicial review. Unum's financial self-interest dictated its claims denial process and Unum maintained a practice of denying claims in bad faith. *See Watson*, 321 F. Supp. 2d 226. In *Watson*, the court cited an impressive list of cases that "reveal[ed] a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics." *Id.* at 247-48. Several states also launched investigations into Unum's questionable claims administration practices, many of which imposed significant fines on Unum for its wrongful denial of meritorious claims. *See, e.g.*, Maine Bureau of Insurance, *Report of the Targeted Multistate Market Conduct Examination*, http://www.maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (last visited Mar. 28, 2008). *See generally*, John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315, 1317-21 (2007).

Given that "ERISA abounds with the language and terminology of trust law," this Court has held that "the courts are to develop a federal common law of rights and obligations under ERISA-regulated plans." *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 110 (1989). Because ERISA is silent regarding the

standard of review for benefit appeals in federal court, reviewing a plan administrator's benefit denial under an arbitrary and capricious standard is merely judicially created law. *See id.* This Court has never mandated deferential review of a plan administrator's decision; on the contrary, *Firestone* holds that the default standard of review for ERISA claims is *de novo*. Indeed, this Court emphasized that "[w]hatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations*. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (emphasis added)).

B. The District Courts Must Review The Benefit Eligibility Determinations of Conflicted Plan Administrators On A *De Novo* Standard Of Review.

Various competing versions of ERISA's standard of judicial review are urged upon this Court, and at one extreme an arbitrary and capricious standard. In the middle are several variations of sliding scale standards and burden shifting regimes proposed by one party and *amici*. And at the other extreme a standard of *de novo* review is urged. In cases where a plan administrator's interest conflicts with those of plan participants, only the *de novo* standard is consistent with the trust duty of loyalty which Congress made the foundation of ERISA's fiduciary provisions.

The duty of loyalty is "the most fundamental duty owed by the trustee to the beneficiaries of a trust." A. Scott & W. Fratcher, THE LAW OF TRUSTS § 170 (4th ed. 1988). Ordinarily the duty of loyalty does not permit trustees to exercise discretion in a

matter in which the trustee has an interest.[4] *Woods v. City Nat'l Bank & Trust Co.*, 312 U.S. 262, 269 (1941); *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928). Yet MetLife argues that the Court should interpret ERISA's duty of loyalty in a manner that permits a fiduciary to exercise discretion in a decision that pits the fiduciary's interests in avoiding benefit payments against the participants' interest in receiving them.

Petitioners' argument, taken to its logical conclusion, is that Congress intended to undermine the duty of loyalty as applied to conflicted, dual role plan administrators.[5] The only evidence that Petitioners point to in support of this novel assertion is that ERISA permits employees of the employer to serve as plan fiduciaries without causing a *per se* violation of ERISA's prohibited transaction rules. *See* 29 U.S.C. § 1108(c)(3). That section alone is hardly sufficient

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[4] Courts have held that trustees with an interest in conflict with trust beneficiaries must either resign their position, *see, e.g.*, *Fidelity Union Trust Co. v. Johnson*, 55 A.2d 813 (N.J. 1947), or petition the court to make decisions on matters in which the trustees have conflicting interests, *see, e.g.*, *Rogers v. Rogers*, 18 N.E. 636 (N.Y. 1888); *Armington v. Meyer*, 236 A.2d 450 (R.I. 1967), or act only in concert with independent trustees, *Dana v. Gring*, 371 N.E.2d 755, 760 (Mass. 1977).

[5] Brief of Petitioners at 33. Petitioners contend that trust law principles require courts to defer to a fiduciary's decisions "even when the fiduciary has a conflict." Brief of Petitioners at 40. In Petitioners' view, the conflict is only one of many factors to be considered by a court. *Id.* In fact, courts will not permit a trustee with a conflict of interest to take discretionary action unless it is clear that the settlor *intended* the trustee to act despite the conflict. *See* A. Scott & W. Fratcher, THE LAW OF TRUSTS § 187.5 n.5 (4th ed. 1988) (cases cited hold that trustee may act despite conflict of interest only if settlor authorized the trustee to act despite the conflict).

evidence of congressional intent to waive the duty of loyalty, for in such situations, courts

> adhere to the rule of strict construction in favor of the trust . . . . The presumption of the law is against [power to act despite a conflict of interest] and, in the absence of clear provision to the contrary, all doubts regarding the scope of the language upon which the claim for such a power is made must be resolved against the party making the claim.

City Bank Farmers Trust Co. v. Taylor, 69 A.2d 234 (R.I. 1949); *see also* Retirement Income Security Act of 1973, S. Rep. No. 127, 93d Cong., 1st Sess. 2, *reprinted in* I Legislative History 587, 615 (indicating that Congress codified certain trust principles because, *inter alia*, it wished to prevent settlors from exempting fiduciaries from common law trust duties as they had been permitted to do under state law).

Given the lack of clear congressional intent to override the strictures of the duty of loyalty, ERISA should be interpreted in a manner that precludes fiduciaries from exercising discretion on matters affecting their own interests. Accordingly, when plan fiduciaries make decisions affecting their interests, courts must apply a *de novo* standard of review. Any other interpretation of ERISA threatens participant security in the benefits ERISA was enacted to preserve and protect.

C. The Exclusive Purpose Rule Requires *De Novo* Review Of Benefit Denials.

ERISA's exclusive purpose rule requires fiduciaries to administer ERISA plans for the exclusive purpose of providing benefits to participants and their beneficiaries. 29 U.S.C. § 1104(a)(1)(A)(I). A fiduciary's discretionary act must promote this purpose

and no other. A decision to deny benefits to participants does not advance the purpose of providing benefits to participants unless there is a compensating advantage to the plan.[9] A decision to deny benefits in an unfunded plan provides no such compensating advantage and therefore falls outside the range of permissible discretionary acts under the exclusive purpose rule. Thus, courts must consider the benefit dispute as a contractual question subject to *de novo* review.

D. The Deferential Arbitrary and Capricious Standard of Review over ERISA § 502(a)(1)(B) Creates an Illogical Presumption that an Interested Decision Maker Acted Against Its Own Interests.

It is illogical and irrational to assume that an insurance company that acts as administrator and fiduciary of a plan for which it also serves as the funding source will function with the same impartiality as the trustee of a funded plan. To say that it was not the foremost objective of Congress through the enactment of ERISA to ensure fiduciary loyalty and neutrality would deny the statute's essential history and purpose. There is simply no legal or logical reason to view an insurer, such as MetLife is in this case, through the favorable (deferential) lens of fiduciary insofar as the matter at issue revolves around the insurer's denial of benefits, since *Firestone* did not obviate ERISA's fiduciary obligations.

Applying a forgiving deferential standard of review to determinations made by insurers is

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[9] Pre-ERISA cases often held that pension plans should be construed in favor of the employees. *See, e.g., Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1354 (8th Cir. 1980); *Thornberry v. MGS Co.*, 176 N.W.2d 355, 360 (Wis. 1970).

altogether inappropriate because ERISA's mandate of fiduciary responsibility is intended to "provide benefits to as many intended employees as is economically possible while protecting the financial stability of the [plan]." *See Elser v. IAM Nat'l Pension Fund*, 684 F.2d 648, 656 (9th Cir. 1982), *cert. denied*, 464 U.S. 813 (1983). It is axiomatic that the insurer in these circumstances must choose between the interests of individual plan beneficiaries on the one hand and the insurer's desire to produce profits on the other. Surely, the overall purposes of ERISA are best served by instructing reviewing courts to apply *de novo* review in determining whether benefits are due under the terms of the plan. Deference is the judicial equivalent of presuming the correctness of the decision to deny benefits. *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990). Such a presumption in the circumstances of an undeniable disincentive to pay benefits runs the serious risk of upholding decisions in which the interests of plan participants and beneficiaries are sacrificed to the insurer's self-interest. The inherent nature of the conflict faced by administrator-insurers dictates an unqualified rule of no deference in cases where a plan administrator that is also the funding source for benefits denies a benefit claim.

Thus, while *Firestone* recognizes that the language of an ERISA plan document may confer discretion to a Plan administrator or fiduciary so as to trigger a deferential standard of review in a subsequent court challenge to a benefit denial by the fiduciary, this deferential standard should apply exclusively where the fiduciary's only obligation is to safeguard the plan's assets. A third party fiduciary's incentive to increase its profits or conserve its own assets would disqualify that third-party fiduciary's decision from deferential review.

Deference to a conflicted plan administrator tips judicial review in favor of the insurer's decision. *See*

e.g., *Brigham*, 317 F.3d 72. On the other hand, the *de novo* standard does no more than establish a level playing field. In *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355 (2002), this Court observed that the deferential standard for reviewing benefit denials is "a feature of judicial review highly prized by benefit plans." *Id* at 384. This Court emphasized that ERISA is silent regarding a standard of review, and remarked that there is no requirement of a "uniformly lenient regime of reviewing benefit determinations." *Id.* at 385. Instead, the Court reiterated its *Firestone* statement that discretion is a matter of contract and plan design. *Id.* at 386. "Nothing in ERISA, however, requires that these kinds of decision be so 'discretionary' in the first place; whether they are is simply a matter of plan design or drafting . . . ." *Id.* In conclusion, the Court stated that "[d]eferential review . . . is not a settled given." *Id.*

CONCLUSION

AARP submits that an ERISA plan administrator that both evaluates and pays claims is operating under a conflict of interest that must be weighed on judicial review of a benefit determination. A *de novo* standard of review should apply on judicial review of a discretionary benefit determination by a plan administrator so conflicted. For the reasons stated above, AARP respectfully urges the Court to affirm the decision of the Sixth Circuit Court of Appeals.

Respectfully submitted,

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IN THE

Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY and LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK & COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF *AMICUS CURIAE* THE AMERICAN COUNCIL OF LIFE INSURERS IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST[1]

The American Council of Life Insurers ("ACLI") is the nation's largest life insurance trade association, representing the interests of 353 member companies operating in the United States. ACLI member companies are the leading providers of financial and retirement security products covering individual and group markets. They provide life, disability income and long-term care insurance, annuities, pension products and reinsurance. In the United States, ACLI members account for 93% of the life insurance industry's total assets, 93% of life insurance premiums, and 94% of annuity considerations. Insurance policies issued by ACLI members include employer-sponsored group disability income insurance policies and group life policies. Annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of products sold by ACLI members in the group employee benefits market are subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). ACLI advocates the interests of life insurers and their millions of policyholders and beneficiaries before federal and state legislators, state insurance departments, administration officials, federal regulatory agencies and the courts.

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1. In compliance with Rule 37.6, *amicus curiae* states that no person or entity other than *amicus curiae*, its members or its counsel made a monetary contribution intended to fund the preparation or submission of this brief, and no attorney for any party authored this brief in whole or in part. In compliance with Rule 37.3(a), *amicus curiae* states that petitioners have filed with the Clerk a consent to the filing of *amicus* briefs, and that respondent has separately consented to the filing of this brief.

Accordingly, ACLI and its members have a substantial interest in the two questions the Court has certified in this case:

> 1. Whether the mere fact that the claim administrator of an ERISA plan also funds the plans benefits, without more, constitutes a "conflict of interest" that must be weighed in a judicial review of the administrator's benefit determination; and
>
> 2. If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?

Resolution of these questions will have significant ramifications for the employee benefits industry. Given the extensive and vital involvement of ACLI's members in the employee benefits field regulated by ERISA, ACLI is well positioned to address these questions, particularly with respect to employee benefit plans funded through the purchase of insurance. A proper understanding of both the functional organization of insurers and the manner in which they underwrite group policies and spread risks is a fundamental predicate to resolving these questions. An overly-simplistic view of the economic realities of the business of insurance has resulted in several Circuit Courts of Appeals imposing a heightened standard of review under the mistaken rationale that a company administering claims on behalf of an ERISA plan cannot also fund the plan's benefits without a "conflict of interest," even when no such conflict has been shown in fact to exist or to have

motivated a particular claims decision. They have disregarded the fact that ERISA's statutory and regulatory framework expressly contemplates and permits a company to provide claim administration services while also funding the benefit claims. They also diminish the significant procedural safeguards ERISA provides that allow a benefit denial stemming from an actual improper motive to be readily detected.

SUMMARY OF ARGUMENT

ACLI respectfully submits that a "conflict of interest" does not exist merely because a company providing claims administration services also funds plan benefits.[2] Without more, no heightened standard of judicial review is necessary. Where the plan contractually grants a company administrating claims the discretion to interpret plan terms and render claim decisions, a traditional deferential standard of review should apply in the absence of a showing that the potential conflict of interest is more than hypothetical and actually tainted the benefit determination. Underlying the decisions of those Circuits which have held otherwise is a blanket and overly-simplistic assumption that providing the claims services, benefit payment and funding contemplated by the contract between an insurer and an employer results in lower profits for the insurer. For a number of reasons, this assumption is fundamentally

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2. The questions presented in this case regarding potentially conflicted administrators and fiduciaries pertain not only to insured plans, but also arguably to self-funded and self-administered plans, and even self-funded plans administered by an outside party that is paid by the plan sponsor. Herein, ACLI focuses primarily on insured plans.

flawed, contrary to the express provisions of ERISA, and detrimental to the cost-effective delivery of benefits contemplated by its drafters.

First, life insurers are in the business of developing, funding and administering retirement and other financial security products at competitive prices with an appropriate return to their stockholders or, in the instance of mutual life insurers, their policyholders. As with any other company, an insurer succeeds in the market by providing quality products and services that are appropriately priced. Accordingly, an insurer's economic success will depend on its ability to accurately underwrite the policies it issues — not on its denial of valid claims.

Second, the premium that an insurance company charges for a particular policy is the product of sophisticated underwriting practices, grounded in complex applications of mathematics, economics, finance, probability, and statistics, that allow insurers to assess the risk of an insured event occurring and to correctly price the cost of insuring that event.[3] In calculating

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3. The importance of underwriting to life insurers is evidenced by the rigorous training and credentialing of their actuaries. In the United States, the Society of Actuaries administers a battery of exams and requires, for associate status, passing five preliminary examinations, providing proof of academic experience in economics, corporate finance, and applied statistics, and completing an eight-module self-learning series. Fellows of the Society must complete an additional three training modules, two exams, and a special fellowship admission course. *See* Society of Actuaries, Admission Requirements to the SOA,

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premiums, underwriters determine not only the revenue needed to cover the anticipated claims experience for the group policy, but also an additional "risk charge" as a cushion should actual claims exceed the anticipated claims experience, contribution to necessary claim reserves and contribution to company surplus. Thus, premiums ordinarily will provide sufficient revenue to pay claims that are validly within the risks that the company assumed in issuing the group policy.

Third, group contracts between insurers and employers generally are subject to annual renewal and, upon renewal, premium adjustments can be made if actual claims experience under a particular group policy

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Spring 2008 Basic Education Catalog (2008), http://www.soa.org/education/course-catalog/spring-exam-session/2008/edu-admission-req.aspx (last visited Feb. 28, 2008). In order to sign statements of actuarial opinion, U.S. actuaries must be members of the American Academy of Actuaries, which requires membership in one of the recognized actuarial societies (*e.g.*, the Society of Actuaries), at least three years of full-time equivalent experience in responsible actuarial work, and continuing education certification. *See* American Academy of Actuaries, Academy Policies: Membership Requirements, *American Academy of Actuaries: 2008 Yearbook*, 67-69 (2008), *available at* http://www.actuary.org/yearbook/index.asp; American Academy of Actuaries, *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, 5-7, 10 (2008), *available at* http://www.actuary.org/qualstandards/qual.pdf. Some pension-related filings to the Internal Revenue Service and the Pension Benefit Guaranty Corporation require the signature of an Enrolled Actuary, who is required to pass two additional examinations. *See* 20 C.F.R. § 901.13(c)-(d); Joint Board Examination Program, http://www.irs.gov/taxpros/actuaries/article/0,,id=97444,00.html (last visited Feb. 28, 2008).

exceeds the originally anticipated claims experience. These adjustments include prospective experience rating, whereby the premiums charged in subsequent years can be adjusted to offset excess claims experience in prior years. For larger group policies, retrospective experience rating also may be used, whereby an insurer can recoup a portion of the excess claims paid under a particular group policy from the policyholder (and/or issue refunds to the policyholder if actual claims are less than the anticipated claims experience). Additionally, insurers have the option, apart from these measures, of "reinsuring" a group policy. Through the purchase of reinsurance, an insurance company can transfer specified risk liability to one or more other insurance companies, thus limiting its own risk under the group policy.

Accordingly, and as several Circuits have properly concluded, the outcome of one particular claim is unlikely to have any significant effect on an insurer's profitability. Indeed, if so remote and minute an economic interest qualifies as a potential conflict of interest, the courts would be hard-pressed to find any actor in the employee benefits process who could not be said to have an economic conflict of interest — whether it be the beneficiary's treating physician, who has an economic interest in retaining his/her professional relationship with the beneficiary, or an outside third party claim administrator of a self-funded plan paid by the plan or its sponsor, who has an interest in retaining its commercial relationship with the plan sponsor.

Additionally, the premise upon which the first certified question is based — that an insurance company "wears two hats" in the employee benefits process, is itself an over-generalization that ignores the functional organization of an insurance company. Claims personnel, who process and determine benefit claims, operate separately and independently from other staff who underwrite policies, manage company reserves and otherwise oversee the financial health of the insurer. Claims staff wear only "one hat" — that of determining the validity of the claim. In the exercise of this function, such staff have a fiduciary duty to the beneficiaries of the plan. They also must adhere to regulatory requirements under both ERISA and state insurance law for proper processing of claims, and their administration of claims is subject to extensive and detailed examination by state insurance regulators.

Finally, ACLI notes that ERISA itself contemplates and expressly permits plan fiduciaries to both make benefit determinations and fund the benefits paid while imposing substantial requirements to ensure the protection of a beneficiary's interests, including the provision of information that may be needed to dispute an adverse claims decision.

With respect to the second certified question, where the claims administrator is granted discretion under the terms of the plan, a traditional deferential standard of review should apply in the absence of some showing that the conflict of interest actually tainted the benefit determination. Such an approach is most consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). *Firestone* indicates that

where a plan confers discretionary authority to determine eligibility for benefits or construe plan terms upon a fiduciary "who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). Clearly, this statement means that a court must consider the conflict in assessing whether there has been an abuse of discretion, but it does not suggest that the discretionary standard of review itself is affected. This statement must be read in light of the common law of trusts, upon which *Firestone* is predicated. Under the common law of trusts, the abuse of discretion standard is not altered merely because a trustee is operating under an apparent conflict of interest. Rather, it must be shown that the trustee's decision was affected by that conflict. *See* Restatement (Second) of Trusts § 187 cmt. e (1959) (court will not interfere with a trustee's exercise of discretionary power unless the trustee "acts dishonestly, or with an improper even though not a dishonest motive, or fails to use his judgment or acts beyond the bounds of a reasonable judgment. The mere fact that . . . the court would have exercised the power differently, is not a sufficient reason"). For this reason, the various other approaches adopted by the lower courts, which range from applying "heightened scrutiny," *i.e*, a "less deferential" standard of review, to a *de novo* review, do not comport with *Firestone* and should be rejected.

ARGUMENT

In the 19 years since *Firestone* was decided, the U.S. Circuit Courts of Appeals have been fragmented on the issue of whether the mere fact that an entity both makes claim determinations and pays the claims, without more, creates a "conflict of interest" sufficient to alter the standard of judicial review. The First and Seventh Circuits have concluded that this fact does not create a conflict of interest and is irrelevant on judicial review. *Wright v. R.R. Donnelly & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Pari-Fasano v. ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 418 (1st Cir. 2000); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998). Others have held that this fact should be considered on judicial review only if the beneficiary can demonstrate not merely that a potential conflict of interest exists, but that the purported conflict actually influenced the benefit determination. *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000); *Sahulka v. Lucent Techs., Inc.*, 206 F.3d 763, 768 (8th Cir. 2000); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160 (8th Cir. 1998) (claimant must present "material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to [the claimant]," *quoted in Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 587-88 (8th Cir. 1999)). Others, including the Sixth Circuit below, have held that this fact does constitute a conflict of interest that must be weighed on judicial

review. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-66 (9th Cir. 2006) (*en banc*); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 387-88 (3d Cir. 2000).

The Circuits are similarly fragmented with respect to the manner in which the standard of judicial review is applied when the claims administrator is deemed to be operating under a conflict of interest. The various approaches defy easy classification. Several Circuits, including the Sixth, have adopted approaches generally referred to as the "sliding scale" approach, under which the degree of deference shown by the court varies inversely with the seriousness of the conflict. *Abatie*, 458 F.3d at 967 (rejecting the "sliding scale" label but adopting a similar approach); *Pinto*, 214 F.3d at 392; *Vega v. National Life Ins. Servs. Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*); *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 587 (8th Cir. 1999). The Tenth and Eleventh Circuits shift the burden of proof to the conflicted fiduciary to establish the reasonableness of the benefit determination. *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004); *HCA Health Servs. of Ga. Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-95 (11th Cir. 2001). The Second Circuit applies a *de novo* review to benefit decisions made by a conflicted fiduciary. *Pulvers*, 210 F.3d at 91.

ACLI respectfully submits that the approach adopted by the First and the Seventh Circuits is most consistent with the underlying economic realties of the insurance market, ERISA's statutory and regulatory framework and the Court's precedent. The mere fact that an insurer administers, determines and funds claims, without more, should not affect the application of a traditional discretionary standard of review.

I. THE MERE FACT A COMPANY BOTH MAKES BENEFIT DETERMINATIONS AND PAYS CLAIMS, WITHOUT MORE, DOES NOT CONSTITUTE A CONFLICT OF INTEREST SUFFICIENT TO AFFECT THE STANDARD OF REVIEW.

A. The Economic Realities Of The Insurance Industry Establish That A Company That Both Determines And Pays Claims Does Not Operate Under A Conflict Of Interest.

1. Market Forces Create An Economic Incentive For Insurers To Pay Valid Claims.

Insurers have an economic incentive to adjudicate group benefit claims fairly and to pay valid claims. A company, irrespective of the nature of the products or services it provides, only succeeds in the marketplace by providing quality products and services that are appropriately priced. Accordingly, an insurer's economic success will depend on its effectiveness in accurately underwriting the policies it issues — not through denial of valid claims.

While those unfamiliar with insurance practices and regulation might assume that denying valid claims is financially advantageous, engaging in such a practice will seriously undermine the marketability of the company's products, thereby negatively impacting its financial condition as customers shift to companies that fairly pay claims pursuant to the terms of the issued policy, and justifiably warrant corrective regulatory action. The First and Seventh Circuits have properly recognized that

market forces in the employee benefits arena provide competing incentives that belie concerns that an insurer is predisposed to deny valid claims. As noted by the First Circuit, "an employer would not want to keep an overly tight-fisted insurer," as the purpose in "having a benefit plan is to please employees, not to result in the employer's bad reputation." *Doyle v. Paul Revere Life Insurance Co.*, 144 F.3d 181, 184 (1st Cir. 1998). As the Seventh Circuit has further noted:

> Companies ... that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans. ... [These employers] want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer ... consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers.

Mers, 144 F.3d at 1021.

Indeed, the structure of insured plans, in which employees participate voluntarily and also typically contribute toward plan premiums, undercuts the argument that fiduciaries will improperly deny valid claims. Where employees contribute to a plan, whether funding it entirely or paying a portion of the premiums, market forces are at work:

> The Plan is a voluntary employee-funded entity, and market forces are at work. If [the insurer] denies claims that Plan participants

> as a group view as valid, those employees will be inclined to withdraw from the plan, thus reducing [the insurer's] role (and presumably its compensation). By the same token, if [the insurer] awards benefits that are viewed as undeserved, Plan participants will experience an increase in their premiums and thus be inclined to withdraw from the Plan (again reducing [the insurer's] role and remuneration). Either way, the structure of the Plan furnishes an incentive for [the insurer] to be unbiased in its handling of claims. This is telling, for courts should not lightly presume that a plan administrator is willing to cut off its nose to spite its face.

Leahy v. Raytheon Co., 315 F.3d 11, 16 (1st Cir. 2002). (Plan funded by employees).

2. The Underwriting Process Ensures That Sufficient Revenue Is Available To Pay Valid Claims.

Proper construction of ERISA requires an understanding of the employee benefits market that it was intended to regulate, including the process of underwriting. The goal of all group underwriting is "to assess risk accurately and equitably, and to calculate an appropriate premium to pay for the coverage." Jane Lithcap Brown et al., Life Office Management Association, Inc., *Insurance Administration* 178 (2d ed. 2002). The success and solvency of an entity issuing group insurance is contingent upon the long run adequacy of the premium rates charged for that group coverage. Burton T. Beam, Jr., *Group Benefits: Basic Concepts and Alternatives* 232 (5th ed. 1993).

Premium rates consist of four basic components: (1) the rate necessary to support the cost of expected or anticipated claims (referred to as a "net premium rate"); (2) a contribution to the company's contingency reserves to provide a cushion against unanticipated or catastrophic amounts of claims (referred to as a "risk charge"); (3) an adjustment for expenses occurred in administering the group policy, such as commissions, premium taxes and other costs associated with acquiring and servicing the group policy; and (4) a contribution to the company's surplus or profit. *Insurance Administration*, *supra*, at 178; *Group Benefits: Basic Concepts and Alternatives*, *supra*, at 232.

In assessing the risk of future claims posed by a particular employee group, an underwriter will consider a multitude of factors, including the reason for the group's existence, the type of group, the stability of the group's composition, the size of the group, the type of industry in which the group works, the geographic location of the group, the level of group participation in the coverage, and group characteristics such as age spread within the group. *Insurance Administration*, *supra*, at 179-85. Underwriters also will consider the expected "persistency" of the group policy, *i.e.*, the probability that the coverage will be continued over a period of years. Persistency is an important factor because a policy in force for a sustained period is more likely to overcome the effects of a single year of excess claims. *Id.* at 185-86.

In calculating an appropriate premium rate, underwriters can use three different approaches: manual rating, experience rating or a blended method that combines both manual and experience rating. Manual rating essentially is the process by which rates are

established for broad classes of groups based on the risk characteristics presented by the groups. *Id.* at 195-96. Manual rating does not consider the prior claim experience for a particular group, and is used where such information is unavailable. In determining the net premium rate (the rate necessary to cover the cost of anticipated claims), insurance companies may rely on their own past claims experience to determine the frequency and severity of future claims, or rely on aggregate data regarding group insurance compiled by sources such as the Society of Actuaries. *Group Benefits: Basic Concepts and Alternatives*, *supra*, at 232.

In experience rating, a particular group's own past claim experience is used to calculate premium rates. Experience rating is based on the assumption that a group's claim experience is likely to remain relatively constant from year to year. Although in some years, a group may have higher or lower numbers of claims and dollar amounts of the claims, the likelihood is high that a group with a relatively stable composition will experience roughly the same level of claims from one year to another. *Insurance Administration*, *supra*, at 195. Premium calculation based solely on experience rating generally is used only for large groups that previously have been insured and have a history of claims. *Id.* It also can be used to develop initial premiums for transferred business, as poor claims experience often is the reason for changing insurance companies.[4] *Group Benefits: Basic Concepts and Alternatives*, *supra*, at 255.

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4. In fact, some insurance companies refuse to write transferred coverage, particularly for large groups, unless the prospective policyholder provides verifiable prior claims experience. *Group Benefits: Basic Concepts and Alternatives*, *supra*, at 255.

In blended rating, premiums will be calculated in part through experience rating and, in part, through manual rating. This approach can be used where some claims experience for the particular group is available, but the information available is not adequate or sufficiently reliable to base the premium solely on the group's prior claims history. The portion of the premium that is based on experience rating will depend on the credibility the underwriter assigns to the group's prior claims experience. Typically, blended rating results in a premium lower than if calculated solely by manual rating, but higher than if calculated by experience rating alone. *Insurance Administration*, *supra*, at 196.

Although the foregoing is just a brief overview of the process by which premium rates are set, it serves to illustrate the comprehensive process by which insurers underwrite group policies in order to ensure that the premiums collected will be sufficient not only to cover valid claims incurred under the policy, but also to establish reserves in the event that actual claims experience exceeds anticipated claims, while still allowing for a reasonable contribution to the company's surplus.

3. Insurers Have Additional Safeguards Should Actual Claims Experience Exceed Anticipated Claims on Group Policies.

The assumption that paid claims necessarily detract from an insurer's profits is further undermined by the fact that insurers have a variety of tools they can utilize as safeguards against the risk that actual claims will exceed the claims anticipated in underwriting the group policy. One common method is rate adjustment. Group

policies generally are subject to annual renewal. When the policy is renewed, a new premium rate is calculated to reflect the group's expected claim experience for the coming year. Such rate is based on the group's claim experience from the prior year, as well as changes in the characteristics of the group, such as average age and gender ratios, and changes in benefit payments. Thus, if a group's actual claims experience for the prior year exceeds that anticipated in calculating the prior year's premiums, the insurer can increase the rate to cover excess claims.[5] *Id.* at 198. This prospective experience rating ensures that to the extent excess claims are incurred, any deficiency in the premium rate will be relatively short-lived. *See Pinto*, 214 F.3d at 388 n.6. (acknowledging that where an insurer adjusts premiums annually under an experience-rated formula, the incentive to deny claims in order to increase profits is lessened if not eliminated).

Retrospective experience rating is another tool that an insurer can use to limit its risk of excess claims, although such rating typically is used only with large groups. Under retrospective premium arrangements, a policyholder assumes some or all of the claim risk, often in exchange for lower up-front premium payments. At the close of the policy year, if actual claims experience exceeds that anticipated in calculating the premium rate, the insurer can collect additional premium from the policyholder. Conversely, if the claims experience is better than originally anticipated, a portion of the

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5. As an alternative to increasing rates, the insurer can suggest a revision to the coverage provided by the policy so that the coverage is adequately supported by the existing premium rate.

premium may be refunded, or alternatively maintained in a "rate stabilization reserve" to offset future fluctuations in that policyholder's claims experience. *Group Insurance*, 534, 545 (William F. Bluhm et al. eds., 3d ed. 2000). Retrospective experience rating therefore creates little financial incentive for an insurer to deny claims. *See Perlman*, 195 F.3d at 981 (retrospective rating eliminates financial interest); *Woo*, 144 F.3d at 1161 n.2 (noting that retrospective rating is not a funding conflict of interest warranting heightened review).

"Reinsurance" also enables an insurer to safeguard against the risk of excess claims by spreading risk to another insurer. Reinsurance in essence is the transfer of a specified risk from one insurer (called the ceding company) to a second insurer (called an assuming company). *Insurance Administration*, *supra* p. 10, at 202. There are various alternatives for specifying the risk to be transferred, including a set percentage of the coverage provided in the underlying policy (*e.g.*, 60% of a claim) and coverage that exceeds a predetermined threshold amount (*e.g.*, all claims in excess of $50,000). Under a stop-loss arrangement for reinsurance, the reinsurer agrees to pay claims that exceed a specified percentage of the total loss incurred above a threshold amount during a specified period and/or a maximum dollar amount. In the long term disability income insurance context, an extended-time arrangement may be utilized, whereby the reinsurer pays benefits after the ceding company has paid benefits for a specified period of time. *Id.* at 222-229.

Proper use of these mechanisms, in conjunction with effective underwriting practices in issuing the group policy, enable an insurer to minimize the risk it ultimately will

bear with respect to excess claims. Thus, the likelihood that excess claims arising under a particular policy could have any significant, negative impact on an insurer's bottom line is remote. The likelihood that a determination of any one particular claim could have such an impact is even more remote.

* * *

Accordingly, ACLI respectfully suggests that in light of the economic realities of the insurance industry, the mere fact an insurer both issues group insurance policies and employs claims personnel to determine claims simply does not establish an actual conflict of interest. Indeed, the alleged financial interest fairly may be considered not only remote, but also minute given the volume of claims an insurer typically handles. If such remote and minute financial interest can be deemed sufficient to create a conflict of interest, essentially any actor in the benefits process can be said to have a conflict of interest. One could also argue that an outside third party administrator hired by the sponsor of a self-funded plan has an economic interest in retaining its commercial relationship with the plan sponsor. Under this approach, taken to its logical conclusion, there are very few cases where courts would ever apply a traditional deferential review — a result which would be contrary to *Firestone*.

B. The Functional Organization And Regulation Of Insurers Preclude Employees Who Determine Claims From Wearing "Two Hats."

1. Benefit Determinations are Solely the Function of Claims Personnel.

The analogy that an insurer that both employs claims decisions personnel and pays benefit claims wears "two hats" is inapposite. The business of insurance involves various personnel who perform highly specialized and separate functions necessary for the provision of insurance. The claim management functions performed by claims employees, who render benefit decisions, are separate and distinct from those performed by the employees who design and market policies, the employees who underwrite policies, the employees who manage company reserves, and the employees who otherwise oversee the financial health of the company. Performance of these functions require separate skill sets. Moreover, insurers separate claim management functions from underwriting and other financial functions in order to avoid conflict of interest issues. Consequently, claims personnel wear only "one hat" — that of determining the validity of the claim.

Determining the validity of a claim is the primary concern of claim management personnel. "Claims management does not mean claims avoidance; nor is it merely a check writing facility to compensate any and all financial losses. The objective is to provide precisely the payment prescribed by the contract, no more and no less." *Group Insurance*, 367 (William F. Bluhm et al. eds., 3d ed. 2000). In performing that function, claims

personnel do not have access to information regarding the premium paid by a particular policyholder, the anticipated claims experience on which that premium is based or the level of actual claims as compared to the claims anticipated at the time the policy was underwritten.

2. In Rendering Benefit Determinations, Claims Personnel Must Comply With Regulatory Requirements Under Both ERISA And State Insurance Law.

In rendering benefit determinations and exercising claim management functions, claim personnel must adhere to regulatory requirements under both ERISA and state insurance law for proper processing of claims. These requirements serve to ensure that benefit claims are not improperly denied. ERISA imposes upon claim personnel a fiduciary duty to act not only in the interest of the claimant, but also the other beneficiaries of the plan when making claim determinations.

In addition to ERISA requirements, discussed *infra* at pp. 20-21, state regulation of insurance also protects beneficiaries' interest in proper claim management. (Pet'r Br. at 37-39.) As part of this regulatory regime, state regulators conduct "market conduct examinations" for the purpose of ensuring consumer protection and detecting improprieties in both claims handling procedures and in the substantive claims decision itself. Market conduct examinations are conducted on both a routine basis, as well as a target basis, such as when a company is the subject of unusually high consumer complaints. I National Association of Insurance Commissioners, *Market Conduct Examiners Handbook* 6 (2004).

As compared to the "macroscopic" focus of required financial examinations intended to assess the overall financial health and solvency of the insurer, the focus of market conduct examinations is "microscopic;" they are intended to detect management errors that may only have a small initial impact, but possibly could result in damaging long term effects. *Id.* at 1. Subjects routinely considered in a market conduct examination include operations/management, complaint handling, marketing and sales, policyholder service, underwriting and claims. *Id.* at 5. Through the use of sampling, a market conduct examiner reviews policies issued and declined, reviews claim handling practices, and directly determines how and why specific claims were handled as they were. *Id.* at 3.

The claims portion of a market conduct examination is designed to assess how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations, and policy provisions. II National Association of Insurance Commissioners, *Market Conduct Examiners Handbook* 936 (2004). The claims portion of the examination includes a litigation survey to determine the extent of suits against an insurer, the basis for the suit, the company's position for denial or settlement offer, and whether bad faith judgments were rendered. *Id.* at 938. The claims portion of a market conduct examination for health and disability income products specifically includes a review of the company's claim procedure and claims training manual. It also includes, *inter alia*, a review to determine whether investigations are conducted in a timely manner, *id.* at 942; whether investigations to determine liability are fair and

reasonable, *id.* at 951; whether claim files are handled in accordance with policy provisions and state law, *id.* at 950; whether claim file documentation is sufficient to support or justify the actual claim determination, *id.* at 948; and, most significantly, whether claims handling practices compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies, *id.* at 957.

C. ERISA Contemplates That Plan Fiduciaries May Both Make Benefit Determinations And Fund The Benefits Paid.

ERISA itself contemplates and expressly permits plan fiduciaries to both make benefit determinations and fund the benefits paid. 29 U.S.C. § 1108(c)(3). It also imposes requirements that ensure the protection of a beneficiary's interests and that the beneficiary is provided information necessary to dispute an adverse claims decision, including the possibility that a benefits decisions may have been improperly motivated.

The regulations implementing ERISA establish a strict and comprehensive regulatory framework to govern the claims process and any resulting benefit disputes. 29 C.F.R. § 2560.503-1. These regulations require, *inter alia*, that:

- The claimant must be provided with written or electronic notification of an adverse benefit determination which sets forth the specific reason(s) for the adverse determination, references the specific plan provisions on which the determination is based, describes any

additional information necessary for the claimant to "perfect" the claim, and explains why such information is necessary. *Id.* § 2560.503-1(g)(1).

- The claimant must have an opportunity within the plan to appeal an adverse benefit determination, and the appeal procedures must provide a "full and fair" review. *Id.* § 2560.503-1(h)(1).

- The notice of an adverse benefit determination must describe the plan's review procedures, the time limits applicable to these review procedures and state the claimant's right to bring a civil action under ERISA if an adverse determination is issued on review. *Id.* § 2560.503-1(g)(1)(iv).

In order to ensure that the claimant is provided a "full and fair" review, the plan's internal appeal procedures must, at a minimum, provide the following:

- The internal appeal must be decided by a fiduciary who is not the initial claim reviewer (or a subordinate of such person). *Id.* §§ 2560.503-1(h)(3)(ii), -1(h)(4).

- The appeal cannot give deference to the original claim decision (i.e. the internal appeal is reviewed *de novo*). *Id.* §§ 2560.503-1(h)(3)(ii), 1(h)(4).

- The claimant must have a right of access to certain specific information relevant to the benefit claim. *Id.* §§ 2560.503-1(h)(2)(iii), -1(h)(4). With respect to disability benefit claims, upon request, the plan also must provide the claimant with the identity of

any medical or vocational experts consulted on the claim, irrespective of whether the expert's advice was relied upon in making the determination. *Id.* §§ 2560.503-1(h)(3)(iv), -1(h)(4).

- The claimant must have an opportunity to submit additional information and/or written comments, and the review must consider all additional information submitted by the claimant, irrespective of whether it was submitted or considered during the initial benefit determination. *Id.* §§ 2560.503-1(h)(2)(ii), -1(h)(2)(iv), -1(h)(4).

- With respect to disability benefits claims, where the benefit denial is based on medical judgment, the fiduciary reviewing the determination must consult with an appropriate health care professional. The health care professional consulted during the review cannot be an individual consulted with respect to the initial determination (nor the subordinate of any such individual). *Id.* §§ 2560.503-1(h)(3)(iii), -1(h)(3)(v), -1(h)(4).

- The claimant must be provided with written or electronic notification of the determination on review which sets forth the specific reason(s) for the adverse determination, the specific plan provisions on which the determination is based, and the claimant's right to request all documents and information relevant to the claim. *Id.* § 2560.503-1(j).

- With respect to disability benefit claims in which the plan relies upon an internal rule, guideline, protocol or other similar criterion in making the adverse determination, notice of both the initial determination and the determination upon review also must either include such internal rule, guideline, protocol or other similar criterion, or state that a copy will be provided free of charge upon request. *Id.* §§ 2560.503-1(g)(1)(v)(A), 1(5)(i).

The claims process mandated by these regulatory requirements ensures that a beneficiary will have appropriate information necessary to challenge the decision of an ostensibly conflicted decision-maker.

II. IF AN INSURER IS DEEMED TO OPERATE UNDER A CONFLICT OF INTEREST MERELY BECAUSE IT BOTH PROVIDES CLAIM ADMINISTRATION SERVICES AND PAYS CLAIMS, A TRADITIONAL DEFERENTIAL STANDARD OF REVIEW SHOULD APPLY ABSENT A SHOWING THAT THE CONFLICT ACTUALLY INFLUENCED THE BENEFIT DETERMINATION.

ACLI respectfully submits that benefit determinations rendered by administrators or fiduciaries who are contractually afforded discretion by the terms of the plan, but also pay claims in addition to rendering the benefit determinations, should be reviewed under a traditional deferential standard of review, absent some showing that the potential conflict of interest actually influenced the benefit determination. The Court suggested in *Firestone* that a conflict of

interest is to be "weighed" in determining whether there has been an *abuse of discretion.* 489 U.S. at 115 (emphasis added) (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). Cleary, this statement means only that a court must consider the conflict in assessing whether there has been an abuse of discretion — not that the standard of review itself should be altered. Any other interpretation would be inconsistent with the common law of trusts, upon which *Firestone* is predicated. Under the common law of trusts, the abuse of discretion standard is not altered merely because a trustee is operating under an apparent conflict of interest. Rather, it must be shown that the trustee's decision was *affected* by that conflict. A court will not interfere with a trustee's exercise of discretionary power unless the trustee

> acts dishonestly, or with an improper even though not a dishonest motive, or fails to use his judgment or acts beyond the bounds of a reasonable judgment. The mere fact that . . . the court would have exercised the power differently, is not a sufficient reason for interfering with the exercise of the power by the trustee.

Restatement (Second) of Trusts § 187 cmt. e (1959). Accordingly, a court may "weigh" the existence of a conflict of interest, but should still apply a traditional deferential standard of review unless there is sufficient evidence to establish that the conflict affected the claims decision.

The various alternate approaches adopted by the Circuits essentially determine the standard of judicial review based on the identity of the administrator or fiduciary rather than whether the purported conflict actually was acted upon. There is no persuasive rationale why the identity of the decision-maker should determine the standard of review. ERISA itself both contemplates and permits a plan administrator or fiduciary to make claims decisions even though that party may be financially affected by the outcome of the decision, 29 U.S.C. § 1108(c)(3), and imposes safeguards to ensure that the interests of plan beneficiaries are adequately protected. Furthermore, as the Court suggested in *Firestone*, the appropriate standard of review under ERISA derives from trust law, wherein fiduciary responsibility is not equated with impartiality. 489 U.S. at 115. When the benefit plan grants entities discretion to make benefit determinations, federal courts should not negate the grant of discretion by altering the standard of review based on the mere potential for a conflict of interest.

The various other approaches to the applicable standard of review, such as the "sliding scale" approach, the "presumptively void" approach or even *de novo* review, are problematic in that nothing in *Firestone*, or in trust law to which the Court analogized in *Firestone*, suggests that the mere potential for a conflict of interest should affect the standard of review where discretion has been granted. Application of a *de novo* standard of review is particularly problematic, as there is no suggestion in *Firestone* that a potential conflict actually negates a grant of discretion. The "sliding scale" approach does not provide sufficiently clear guidance to

lower courts attempting to apply the standard of review. Circuits following this approach often essentially wind up applying a *de novo* standard of review, even though the Court declined to adopt this approach in *Firestone*. The uncertainty engendered by this approach also is problematic because it undermines Congress' key objective in enacting ERISA – to establish a "uniform administrative scheme" for ERISA-covered benefit plans and a uniform body of federal common law for enforcement of such plans. *Fort Halifax Packing Co. v. Coyne, Inc.*, 482 U.S. 1, 9 (1987). Congress sought to establish this uniformity as part of its effort to encourage employers to establish benefit plans by eliminating the difficulties presented by and increased costs resulting from a patchwork of conflicting state and local laws.

Finally, the alternate approaches also undervalue the role that deference plays in the formation of benefit plans. Upholding a plan's grant of discretionary authority through application of a deferential standard of review provides plan sponsors with a degree of contractual control over the benefit plan and promotes its affordability. [6] ERISA does not mandate what, if any,

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6. Nationwide, the rapidly rising cost of health insurance premiums has far outpaced wage growth and inflation for some time now. *See, e.g., The Uninsured and Rising Health Insurance Premiums: Hearing Before the Subcomm. On Health of the H. Ways & Means Comm.* 108th Cong. 108-50 (Mar. 9, 2004) (Statement of Douglas Holtz-Eakin, Director, Congressional Budget Office). Given that increasing litigation, large awards, and class actions are among the major drivers of increasing insurance costs, *see* PriceWaterhouseCoopers for the American Ass'n of Health Plans, *The Factors Fueling Rising Healthcare Costs* 9 (2002) *cited in* Governor's Task Force on Access to Affordable Health Insurance, (Cont'd)

benefits an employer must provide and employers have large leeway to design their plans. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). Given the enormously wide range of issues that can arise in rendering benefit decisions under any plan, it is not possible to predict every type of issue and claim that may arise. Discretion and a deferential standard of review enable the plan to resolve such issues in a manner that best protects the interests of all participants in the plan and reduce the danger that the outcome will be strongly influenced by unusual facts that may be present in a particular case.

Accordingly, in the absence of an actual conflict of interest and where the states are already well-empowered to address and remedy inappropriate claims administration, the marginal benefits of *de novo* or "sliding scale" review to the average employee are minimal at best. The traditional deferential approach is the most appropriate approach, and there is no legal or economic justification for change.

(Cont'd)

Final Report 30 (Feb. 15, 2004), *available at* http://www.fdhc.state.fl.us/affordable_health_insurance/PDFS/task_force_report_021504_final.pdf, permitting *de novo* or "sliding scale" judicial review on the basis of perceived and not actual conflicts of interest is far from Congress' intent in enacting ERISA to promote the formation and uniform regulation of employee benefit plans.

CONCLUSION

For the foregoing reasons, ACLI respectfully submits that the mere fact a claims administrator both renders claims decisions and pays claims does not constitute a conflict of interest sufficient to affect the standard of judicial review applicable to that benefit determination.

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No. 06-923

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In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK & CO,
Petitioners,

v.

WANDA GLENN

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE AMERICAN DENTAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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BRIEF OF THE AMERICAN DENTAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

INTEREST OF *AMICUS CURIAE*[1]

The American Dental Association (ADA) is the world's largest professional association of dentists. The ADA is committed to the public's oral health, and to the ethics, science and professional advancement of dentistry. On behalf of its more than 155,000 members, the ADA occupies a prominent role in leading the profession through initiatives in advocacy, education, research, and the development of standards that are essential for the safe, appropriate, and effective delivery of oral healthcare. The Association is vitally concerned with access to care issues and serves as a principal advocate on issues affecting oral health.

The Association's advocacy on such important health issues includes submissions to legislative bodies and judicial tribunals. In cases that address questions of concern to the Association, its members, and the public, the ADA has participated and will continue to participate as *amicus curiae*. This is just such a case. The arguments advanced by the petitioners – particularly their negative comments

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[1] The parties have consented to the filing of this brief, as reflected in letters filed with the Clerk of Court. Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

about healthcare providers – could have adverse ramifications for the dental profession and the public. Accordingly, the ADA submits this *amicus curiae* brief so that the Court will have a fuller, more accurate, and better informed understanding of the context in which the issues in this case affect the dental profession and the public.

SUMMARY OF ARGUMENT

In seeking reversal of the Sixth Circuit's judgment in this case, petitioners advocate positions that are contrary to ERISA's statutory language and legislative purpose, and also contrary to judicial construction of the fiduciary duties owed to ERISA plan beneficiaries. Accordingly, on the grounds explained in detail in respondent's brief, the decision below should be affirmed.

In addition to the sound rationale for affirmance set forth by respondent, there are further compelling reasons why this Court should reject petitioners' contentions. First, petitioners' entire analytical construct depends on assumptions that lack an empirical or evidentiary basis. Indeed, petitioners' contentions are directly contrary to scholarly studies and to the experience of courts that have dealt with the real-world situations arising in the administration of ERISA plans.

Among the most readily identifiable flaws in petitioners' analysis are the propositions that: (1) it is not a conflict of interest for an ERISA insurer to also serve as plan administrator; (2) it is in the long-term interest of every dual-role insurer-administrator to make all eligibility decisions fairly

and accurately, without regard for the short- or long-term financial ramifications; (3) every dual-role insurer/administrator will, in every case, make the same eligibility determination that would have been made by an administrator whose fiduciary duty to plan beneficiaries constitutes his sole, undivided role.

These flaws expose the error in petitioners' contention that the clear conflict of interest under which dual-role insurers/administrators must labor should be totally ignored by courts that sit in review of claims eligibility decisions. The ineluctable fact is, such conflicts are real, pervasive and affect benefits decisions in multiple ways, whether consciously or non-consciously, whether overtly or subtly.

The regime that petitioners posit would have a particularly deleterious impact on the relationship between healthcare professionals and their patients. Treatment and care decisions by dentists and patients must have as their paramount objective the best interest of the patient. That requires open and candid communication. And it requires respect for the judgments reached by trained professionals with the closest first-hand knowledge of their patients. Because petitioners' arguments would far too facilely reject the healthcare provider's professional assessment in favor of the second-guessing by an insurer/administrator with a financial conflict of interest, this Court should affirm the judgment in this case in favor of respondent.

ARGUMENT

THE INHERENT CONFLICT THAT EXISTS FOR DUAL-ROLE INSURERS/ ADMINISTRATORS IS PROPERLY THE SUBJECT OF ATTENTION BY COURTS REVIEWING COVERAGE DECISIONS

On multiple levels, there is no merit to petitioners' contention that the inherent conflict of interest affecting dual-role insurers/administrators should be disregarded or given *de minimis* weight by reviewing courts. In order best to comprehend the pervasive error in petitioners' argument, it is advisable to begin with a central flaw on which petitioners' entire analysis rests. The foundation on which petitioners build their analytical structure is the premise that a dual-role administrator has only a *potential* conflict of interest between its fiduciary responsibility to plan beneficiaries and its fiscal relationship to the insurance carrier. In petitioners' view, this potential conflict of interest is not an actual conflict of interest. But that counterfactual premise is belied by the law of trusts on which Congress relied in enacting ERISA. Petitioners' premise is also belied by the experience of implementing ERISA and other analogous programs. And it is further belied by scholarly studies of human behavior in the fields of economics and psychology.

In every other context, the inherent tension between administering a fund (determining eligibility for coverage) and bearing the costs of payments from that fund is understood to be a conflict of interest. To be sure, in certain limited

circumstances such conflicts are tolerated – even permitted – but only when accompanied by the hallmarks of full disclosure, unambiguous waiver, and transparency providing assurance of compliance with fiduciary duties. Congress did not depart from this model in enacting ERISA. In allowing for the possibility that a single entity – or two related entities – could serve as a plan's benefit administrator and underwriting insurer, Congress did not determine that such dual roles do not constitute an actual conflict of interest. Rather, Congress intended that courts would be cognizant of and sensitive to such conflicts of interest in reviewing the decisions of dual-role insurers/administrators. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) ("if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed . . . . ").

A. Dual-Role Insurers/Administrators Act Under A Conflict Of Interest.

For years, this Court and the lower federal courts that are on the front line of decision-making under ERISA have understood that the functions of administrator and underwriter of a benefit program are inherently in tension. *See Firestone*, 489 U.S. at 113; *Denmark v. Liberty Life Assurance Co. of Boston*, 481 F.3d 16, 29-31 (1st Cir. 2007); *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997). On the one hand, the insurer has an ultimate interest in maximizing the margin between benefit outlays and funds received in underwriting. *See Armstrong*, 128 F.3d at 1265; *see also Doe v.*

Travelers Ins. Co., 167 F.3d 53, 57 (1st Cir. 1999); *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998); *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1561-62 (11th Cir. 1990). On the other hand, it is bound as a fiduciary to provide benefit coverage to plan participants without regard to effect on the funding entity. *See Pegram v. Herdrich*, 530 U.S. 211, 223-24 (2000). In permitting an insurer both to underwrite and administer ERISA plans, Congress did not declare the resulting conflict of interest to be nonexistent – or merely "potential." Nor did Congress absolve the insurer/administrator of those conflicts or preclude courts from considering the conflicts in any judicial review of benefit determinations. Rather, Congress drew extensively on well-established principles from the law of trusts. *Firestone*, 489 U.S. at 110. Under these principles, the existence of a conflict of interest necessarily constitutes an important consideration in judicial assessment of actions undertaken by a fiduciary.

1. A dual-role insurer/administrator's long-term interest in denying claims will be reflected in improper rejection of individual claims.

A second level of flawed generalizations on which petitioners rely consists of their contentions that: (1) an insurer's long-term economic interest will always favor paying claims – even close claims – promptly and fully; and (2) an insurer's dual-role as plan administrator is fully consistent with its fiduciary duties to patients and imposes no impediment to the pursuit of such beneficent long-term objectives.

Reality is contrary to petitioners' economic fantasy. A more discerning analysis reveals that the interest of an insurer who is both underwriter and benefits administrator is to reach an optimal balance between immediate profit maximization and alienation of its customers (which are the employers, not the insured employees such as respondent Glenn), within the constraints of the applicable regulatory scheme. *See Brown*, 898 F.2d at 1561. Those economic forces do not preclude bias or misconduct in administering an ERISA plan.

Courts have seen these principles at work in a number of areas of economic regulation. For example, just as a monopolist has an incentive to charge prices that are both supra-competitive and just below what will entice competition to enter the market, an insurer wearing two hats has an incentive improperly to deny claims up to a level just below what will trigger large employer defections, state regulatory investigations or sanctions.

Decision-making by rational agents can reflect very complex sets of interactions. *See generally* Colin F. Camerer, *Behavioral Game Theory: Experiments in Strategic Interactions*, 465-73 (Princeton 2007). A monopolist should be able to see that it will gain overall profit if it is willing to accept a longer time-line. It should price near, but short of, the limit. Similarly, it should tolerate small competitors taking a small share of the market at lower prices operating under its umbrella. The existence of the small competitors makes competition appear more robust than it really is. A monopolist need not (and

rationally should not) immediately raise prices to the full monopoly return, *e.g.*, limit pricing or umbrella pricing.[2]

An insurer that both funds and administers an ERISA plan has a long-term interest to deny claims at rates just below what will alienate its customers and their employees. In this respect, the insurer's position is analogous to that of a monopolist for whom limit pricing or umbrella pricing[3] is often the optimal strategy. For the dual-role insurer/administrator, that strategy maximizes its profit on underwriting. The rational insurer will aim

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[2] "Limit pricing" is setting one's price just below the level that a prospective entrant to the market would need to charge in order to sustain a successful entry. *Phototron Corp. v. Eastman Kodak Co.*, 842 F.2d 95, 101 (5th Cir. 1988). While detecting and remedying limit pricing can be difficult, it nevertheless exists and harms competition. *See, e.g.*, Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law* ¶ 736b1 (3d ed. 2002) ("The limit price is intended by the monopolist to impair the opportunities of rivals, and, if successful, it does prevent competition from arising.").

[3] "Umbrella pricing" is where a firm with market power raises prices to a level that allows small, inefficient firms to enter the market and gain limited market share. *See* Gloria J. Hurdle & Henry B. McFarland, *Criteria for Identifying Market Power: A Comment on Baumol and Swanson*, 70 Antitrust L.J. 687, 693-94 (2003). While entry may appear to undermine the conclusion that the monopolist actually possesses market power, such a conclusion overlooks the possibility that the new entrants may be less efficient and that "[a] firm with market power generally will find it profitable to lose some share of the sales in a market in order to charge higher prices on the remaining sales." *Id.*

to deny as many claims as it can without crossing over into such pervasive denial that it will suffer (comparative) customer defections or an impaired reputation. Under that economically rational strategy, close cases – which are the cases most likely to be reviewed by a court and most likely to be adversely affected by the institutional conflict of interest – will suffer particularly from the effect of the inherent bias that flows from the conflict.

These incentives flow downward to affect individual benefit decisions by administrators who know, consciously or not, that their employer (the insurer) benefits from denying claims. Since no single improper denial will cause defection of customers, who are the employers of beneficiaries rather than the beneficiaries themselves, there is no effective counterbalance to the administrator's knowledge of the insurer's financial interest in denying individual claims.

Knowledge of the insurer's interests need not be at the forefront of the administrator's mind to affect the evaluation process and decision. Cognitive science teaches that biasing of the sort at issue here is no less pervasive because non-conscious.[4] There is

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[4] Subtle, non-conscious bias is still bias. For example, studies show that as orchestras moved to auditions where the performer was not seen and entered silently, the gender mix of new players altered. The increase in women members appears related almost entirely to removal of signals (such as the sound of high heels on wooden floors) which unconsciously biased evaluators. *See* Cecilia Rouse & Claudia Goldin, *Orchestrating Impartiality: The Impact of Blind Auditions on Female Musicians*, 90(4) American Economic Review 715-41 (Sept. 2000).

extensive, robust evidence that even highly self-aware individuals are influenced, albeit unconsciously, by economic interests, investment in prior decisions, and so on. For example, scholarly studies indicate that results of scientific research can have a positive correlation with funding source.[5] Further studies show that information and evidence is assessed to fit existing conclusions;[6] that inconsistent and inconvenient evidence is subjected to critical, unfavorable scrutiny and is devalued;[7] and that even the most scrupulous person tends to

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[5] *See, e.g.*, Justin E. Bekelman, Yan Li, & Cary P. Gross, *Scope and Impact of Financial Conflicts of Interest in Biomedical Research: A Systematic Review*, 289(4) JAMA 454-65 (2003); Joel Lexchin, Lisa A. Bero, Benjamin Djulbegovic & Otavio Clark, *Pharmaceutical Industry Sponsorship and Research Outcome and Quality: Systematic Review*, 326 Brit. Med. J. 1167-70 (2003).

[6] Keith J. Holyoak & Dan Simon, *Bidirectional Reasoning in Decision Making by Constraint Satisfaction*, 128 J. Experimental Psychol. – General 3-31 (1999); J. Edward Russo, Margaret G. Meloy, & Victoria H. Medvec, *Predecisional Distortion of Product Information*, 35 J. Marketing Research 438-52 (1998); J. Edward Russo, Victoria H. Medvec, & Margaret G. Meloy, *The Distortion of Information During Decisions*, 66(1) Org. Behavior and Human Decision Processes 102-10 (1996); Derek J. Koehler, *Explanation, Imagination, and Confidence in Judgment*, 110(3) Psychol. Bulletin 499-519 (1991); Charles G. Lord, Lee Ross, & Mark R. Lepper, *Biased Assimilation and Attitude Polarization: The Effects of Prior Theories on Subsequently Considered Evidence*, 37(11) Journal of Personality and Social Psychol. 2098-109 (1979).

[7] Thomas Gilovich, *How We Know What Isn't So: The Fallibility of Human Reason in Everyday Life* (Free Press 1991).

overvalue his or her own assessments and interests.[8] Since these sorts of effects can be found even in cases where highly skilled individuals are on guard against the influences, how much more likely is it that decisions made by less well-trained claims administrators acting on individual cases will be unaffected by bias resulting from an inherent conflict of interest?[9] Clearly, there is ample room for a structural conflict of interest to affect claims decisions.

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8 *See, e.g.*, Don A. Moore, Philip E. Tetlock, Lloyd Tanlu, & Max H. Bazerman, *Conflicts of Interest and the Case of Auditor Independence: Moral Seduction and Strategic Issue Cycling* 19 (American Accounting Association, Working Paper # 03-115, 2004).

9 *See, e.g.*, Thomas A. Buchman, Philip E. Tetlock, & Ronald O. Reed, *Accountability and Auditors' Judgments About Contingent Events*, 23(3) J. Bus. Fin. & Accounting 379-98 (1996); Andrew D. Cuccia, Karl Hackenbrack, & Mark W. Nelson, *The Ability of Professional Standards to Mitigate Aggressive Reporting*, 70(2) Accounting Rev. 227-48 (1995).

2. Petitioners' arguments are contrary to this Court's requirement that a dual-role insurer/administrators' inherent conflict of interest be recognized in judicial assessments of claims rejections.

In positing the contention that courts should ignore – or give only *de minimis* weight to – a dual-role insurer/administrator's conflict of interest, petitioners' view is directly contrary to multiple decisions of this Court. In *Firestone*, this Court required that, where an ERISA fiduciary has a conflict of interest, a reviewing court "must" consider and give weight to the conflict "as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (citation omitted). That sensible rule is fully consistent with the established judicial recognition that even where an insurer is permitted to function in dual roles, "ERISA does require . . . that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions." *Pegram, 530 U.S. at 225.* In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002), this Court elaborated on the same point, observing that it is appropriate to keep an "eye peeled for conflict of interest." These teachings are fundamentally at odds with the pernicious new standard that petitioners urge.

The wisdom of this Court's guidance in *Firestone* is reflected in the subsequent decisions of lower courts that have been called upon to consider decisions made by dual-role insurers/administrators. For example, in *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006), the court discerned

that *Firestone* advanced ERISA's objectives by discarding an approach that "wrongly aligns incentives." As the Ninth Circuit explained, the danger inherent in the type of regime that petitioners advocate is that it fails to encourage administrators "affirmatively to demonstrate their impartiality and the reasonableness of their decisions," and that it instead rewards administrators "for suppressing dissent and denying claims with as little explanation as possible." *Id.*

Similarly, the Third Circuit pointed out in *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000) that ERISA litigation typically occurs only in close cases and:

> [T]here would seem to be insufficient incentive for the carrier to treat borderline cases (unlikely to become causes celebres) with the level of attentiveness and solicitude that Congress imagined when it created ERISA "fiduciaries." Rather, insurance carriers have an active incentive to deny close claims in order to keep costs down and keep themselves competitive so that companies will choose to use them as their insurers . . . . To amplify, while in a perfect world, employees might pressure their companies to switch from self-dealing insurers, there are likely to be problems of imperfect information and information flow.

In short, courts that have addressed the empirical records of conduct by dual-role insurers/administrators understand precisely why the structural conflict of interest cannot be ignored or glossed over with minimal concern.

B. The Nature Of The Patient-Provider Relationship Necessarily Requires That There Be Minimal, If Any, Interference with the Provider's Decision-Making and that the Provider's Assessments be Given Appropriate Respect.

The bond between patient and healthcare provider, whether dentist or physician, begins as and remains a type of fiduciary relationship. Dentists and physicians are bound from the outset to consider first and only the health and well-being of the patient. Providers, who deal directly with patients undeniably are better situated to assess the needs of patients than are benefit plan administrators.

1. Providers have direct duties of care to attend to their patients' best interests.

Healthcare providers owe direct professional, moral, and legal duties of care to place paramount importance on the patients' best interests and health care. Dentists are required to "have the benefit of the patient as their primary goal." ADA, *Principles of Ethics and Code of Professional Conduct*, Preamble, http://www.ada.org/prof/prac/law/code (last updated 2005). This tenet is the cornerstone for the principles embodied in dentistry's ethics code. For example, according to the principle of beneficence dentists are under an affirmative duty to

"promote the patient's welfare." *Id.*, Section 3. Pursuant to the principles of veracity and justice, dentists must forthrightly disclose conflicts of interests and deal truthfully and fairly with patients, and are admonished not to exploit patient trust for their own financial gain. *Id.*, Sections 4 & 5. Safeguarding patient welfare is an integral responsibility for the dentist in the dentist-patient relationship.

Treating physicians, too, must "place[e] patient welfare before all other concerns," and must never "place their own financial interests above the welfare of their patients." AMA, *Code of Medical Ethics*, E-8.02, 8.03, *available at* http://www.ama-assn.org/ama/pub/category/ 2498.html (last updated 1998, 1994, respectively); *see also id.* E-10.015 ("ethical obligations to place patients' welfare above their own self-interest"); AMA, *Principles of Medical Ethics*, Principle VIII, *available at* http://www.ama-assn.org/ama/pub/ category/2512.html (last updated 2001) (a physician "shall, while caring for a patient, regard responsibility to the patient as paramount"). Psychologists have similar duties towards patients. *See, e.g.*, APA, *Ethical Principles of Psychologists and Code of Conduct* 2002, Principle A, *available at* http://www.apa.org/ethics/code2002.pdf (last updated 2002).

2. Providers are better situated to assess patient needs than are plan administrators.

Plan administrators do not examine or treat patients. Their expertise does not lie in recognition of the best interests of the patient. Nor is the

administrator devoted to the well-being and healthcare needs of the patient. This is in sharp contrast to the healthcare provider, who has a direct duty of care.

Of course, healthcare providers are far more likely to be engaged directly with the patient than is a plan administrator. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832 (2002). A healthcare provider interacts with the patient on a face-to-face basis. The diagnostic process that results from physical examinations and ongoing communications leads to individual treatment recommendations. This personal engagement is particularly important because so much of diagnosis and treatment involves assessment of a patient's articulation of his or her somatic impression. Assessment of pain, for example, requires careful attention to how a patient describes and expresses physical sensations. Such information is uniquely accessible to the provider, as opposed to an administrator, yet is essential for proper claim evaluation. *See, e.g.*, Susan A. Flocke, *The Impact of Insurance Type and Forced Discontinuity on Delivery of Primary Care*, 45 J. Fam. Prac. 129, 132 (1997); *Textbook of Primary Medical Care Medicine*, 93 (John Nobel ed., 3d ed. 2001) (discussing patient's report of pain as "the most reliable information available").

3. Even in the rare situations when a provider may have a conflict of interest with the patient, any such conflict will be less severe than the pervasive institutional conflict of interest that affects dual-role insurers/administrators.

Petitioners devote extended argument to the proposition that healthcare providers may, at times, face conflicts of interest in dealing with patients. That, of course, can occur, but there are powerful reasons why the possibility of a rare provider-patient conflict should not be the catalyst for a legal rule that, in every situation, eliminates judicial scrutiny of the conflict of interest that necessarily besets the dual-role insurer/administrator.

There are, in the first instance, professional standards that govern financial and ethical conflicts when they arise. ADA, *Principles of Ethics and Code of Professional Conduct*, *supra*, 5.C, 2.B.1.; AMA, *Code of Medical Ethics*, *supra*, E-8.032, 8.035. In any event, such conflicts are both rarer, and more easily ameliorated than the conflicts continually affecting a dual-role insurer-administrator. In many instances the matter can satisfactorily be addressed through full disclosure. In others, a neutral second opinion will alleviate the problem. In rare situations, the proper course may be for the provider to withdraw. But it would never be correct for a provider to follow the approach that the dual-role insurer/administrator takes, *viz.*, to characterize its conflict as merely "potential" and then assert that a reviewing body should ignore the existence of a conflict altogether.

The conflict of a dual-role insurer/administrator is profoundly different from the rare, incidental, healthcare provider conflicts of interest. The former conflict goes to the very recognition of the patient's well-being and needs, because the dual-role insurer/administrator's interests cut against — in

fact they are diametrically opposed to – recognition of claim validity. Accordingly, the insurer's interests are directly at odds with the interests of the patient (or plan beneficiary), a person to whom a fiduciary duty is owed.

The conflict of interest of a dual-role insurer/administrator is also more pervasive and insidious because it is structural. For the dual-role insurer/administrator, the conflict of interest may permeate all of its decision-making.

At the end of the day, the permutations petitioners offer for ignoring or minimizing judicial consideration of their inherent conflicts of interest are all contrary to the language and purpose of ERISA and contrary to sound public policy. There should be no doubt that the balance carefully crafted by Congress would be disturbed if a provider's alleged conflict of interest could be considered in a review by a dual-role insurer/administrator but the insurer/administrator's inherent conflict of interest could not be considered by a reviewing court.

C. Administrator Decisions Made Under A Conflict Of Interest Should Be Subject To Substantive Review That Weighs The Conflict As A Factor.

Decision-making is intrinsically suspect when a conflict of interest exists – especially in the context of a fiduciary relationship. The subtle influence of structural conflicts, no less than the overt pressure of direct monetary reward, justifies searching review of the resulting decisions. Of course, that does not mean that in every instance the dual-role insurer/administrator's decision must be rejected. Nor does a standard that acknowledges the influence of such conflicts necessarily mean that there can be no flexibility in reviewing administrator decisions. The fact of a conflict should be considered as one, albeit initially significant, factor to be weighed in review. Where there are additional signs of conflict, *e.g.*, the absence of insulation of those making claims decisions, the presence of performance metrics or compensation criteria that reward claim denials, a reviewing court should look more closely at the decision. Similarly, where there are additional indications that a conflict has overtly infected administrative decisions, courts should be empowered to provide an appropriate cure.

Petitioners' invitation for this Court – and all courts reviewing decisions by dual-role insurers/administrators – to ignore conflicts of interest is flatly inconsistent with ERISA's grounding in and development from the law of trusts. Indeed, "[u]nder ERISA, plan administrators are, for most purposes, treated like common-law trustees."

Post v. Hartford Ins. Co., 501 F.3d 154, 162 (3d Cir. 2007) (citing *Firestone*, 489 U.S. at 110)). As this Court noted in *Firestone*, the law of trusts requires that courts take a trustee's conflict of interests with a beneficiary into account. 489 U.S. at 115 (citing *Restatement (Second) of Trusts* § 187 cmt. d (1959)). Since *Firestone* was decided, the *Restatement (Third) of Trusts* has further clarified that "while it is permissible for a trustee to act under a structural conflict of interest, its discretionary decisions 'will be subject to especially careful scrutiny.'" *Post*, 501 F.3d at 162 (quoting *Restatement (Third) of Trusts* § 37 cmt. f(1) (2003)).

"Trust law proscribes conflicts of interest because of the significant danger that improper motivations *might* affect a conflicted fiduciary's decision-making, not because proof of a conflict establishes causation." Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 Okla. L. Rev. 637, 662 (2005); John H. Langbein, *Questioning the Trust Law Duty of Loyalty: Sole Interest or Best Interest?*, 114 Yale L.J. 929, 931 (2005) ("Courts invalidate a conflicted transaction without regard to its merits — 'not because there is fraud, but because there may be fraud.' '[E]quity deems it better to . . . strike down all disloyal acts, rather than attempt to separate the harmless and the harmful by permitting the trustee to justify his representation of two interests.'") (alteration in original) (internal citations and quotation marks omitted). Under well-established canons of trust law, trustees operating under a self-dealing conflict of interest are subjected to the "no-further-inquiry" rule, relieving beneficiaries of the

evidentiary burden of proving causation. *See, e.g.*, *Wendt v. Fischer*, 154 N.E. 303, 304 (N.Y. 1926) (Cardozo, J.). Furthermore, under the "no-further-inquiry" rule, once a conflict of interest is demonstrated, courts presume that the conflict of interest influenced the trustee's decision-making and hold that the presumption of taint is irrebuttable. *See, e.g.*, *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928) (Cardozo, J.).

Petitioners' arguments are also contrary to ERISA's language. The statute expressly requires a fiduciary – defined as anyone who "exercises any discretionary authority or discretionary control respecting management of [a] plan or exercises any authority or control respecting management or disposition of its assets," 29 U.S.C. § 1002(21)(A)(i) – to provide a "full and *fair* review" of claim denials, 29 U.S.C. § 1133(2) (emphasis added). Turning a blind eye or conferring a bare nod in the general direction of a structural conflict of interest does not comport with the clear statutory mandate.

D. The Presence Of Additional Factors Warrants Heightened Concern For Bias And Hence Closer Review Of Decisions By A Dual-Role Insurer/Administrator.

There are a variety of additional factors suggestive of bias in decision-making by a dual-role insurer/administrator the presence of which will indicate the need for closer review. *See* Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim* Cases, 50 Am. U. L. Rev. 1083, 1155 (2001) (collecting cases). Where the claim

administrator's compensation is affected by approval/denial rates or metrics derived from approval and/or denial rates, there will be subtle and not-so-subtle pressures for denial in all but the clearest cases of entitlement. *See generally* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315 (2007). Performance bonuses are, after all, a significant incentive for desired conduct, and where the bonus (or other compensation) derives from denial of claims, there must be error favoring denial. Similarly, a claims administrator who is an at-will employee likely faces, or at least perceives, pressure to deny claims.

Patterns of denial of claims that disregard or devalue assessments of treating healthcare providers are most assuredly suggestive of bias. Such a pattern may indicate that factors other than legitimacy of the claim is affecting the claims administration decisions, as may a preference for the evaluations of insurer-retained healthcare providers. Of course, where the administrative file itself demonstrates or evidences bias, the decision should be subject to closer and more skeptical review than otherwise. These factors help illustrate the many ways in which petitioners' arguments run counter to the language and purpose of ERISA, defy common sense and human nature, and invite an altogether untenable result.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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METROPOLITAN LIFE INSURANCE COMPANY AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,
Petitioners,

v.

WANDA GLENN,
Respondent.,

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS, THE AMERICAN BENEFITS COUNCIL, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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BRIEF OF AMERICA'S HEALTH INSURANCE PLANS, THE AMERICAN BENEFITS COUNCIL, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

America's Health Insurance Plans, the American Benefits Council, and the Chamber of Commerce of the United States of America respectfully submit this brief as *amici curiae* in support of petitioners, with the written consent of the parties.[1]

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[1] Letters of consent have been filed with the Clerk. No party or counsel for a party to this case authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity other than *amici curiae*, their mem-

INTERESTS OF *AMICI CURIAE*

America's Health Insurance Plans ("AHIP") is the national association representing nearly 1,300 member companies that collectively provide health insurance coverage to more than 200 million Americans. The vast majority of individuals insured by AHIP members are participants in, or beneficiaries of, employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The association's goal is to provide a unified voice for the health care financing industry, to expand access to high quality, cost-effective health care to all Americans, and to ensure Americans' financial security through robust insurance markets, product flexibility and innovation, and an abundance of consumer choice.

The American Benefits Council ("ABC") is a broad-based nonprofit trade association founded to protect and foster the growth of this Nation's effective and important privately sponsored employee benefit plans under ERISA. The members of ABC include both small and large employer sponsors of employee benefit plans, as well as plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 250 members sponsor, administer or advise plans covering more than 100 million plan participants.

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bers, or their counsel has made a monetary contribution to the preparation or submission of this brief.

The Chamber of Commerce of the United States of America ("the Chamber") is the world's largest business federation, representing an underlying membership of over three million businesses and organizations of every size, in every industry sector, and from every geographic region of the country. A principal function of the Chamber is to represent the interests of its members by filing amicus briefs in cases involving issues of vital concern to the nation's business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital importance to them, their employees, and the employees' dependents, and to the Chamber.

INTRODUCTION AND SUMMARY

For more than 30 years, ERISA's system of uniform regulation for employee benefit plans has fostered the development of widespread employment-based coverage for disability, health, and other benefits. ERISA does not require that employers adopt benefit plans, nor does it mandate any particular terms. Plan design is a "settlor" function, subject to the discretion of the employer who sponsors the plan. One critical component of plan design is the authority of the plan fiduciary responsible for administering the plan and determining eligibility for benefits. As this Court recognized in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), employers may – and in amici's experience, generally do – confer on plan fiduciaries full discretion to administer the plan and make plan benefit determinations.

And ERISA expressly contemplates that employers may confer that discretion on an entity that is also the source of funding for the plan. *See* 29 U.S.C. § 1108(c)(3). For insured plans, a single entity can reduce administrative expenses by serving as both insurer and plan fiduciary. For self-funded plans, the employer itself or an internal benefits committee can serve as fiduciary without the need to contract with a third party. Because of these efficiencies, it is common for employer-sponsored benefit plans to utilize a single entity to perform fiduciary (claims administration) and non-fiduciary (insurance) functions.

The regulatory framework established by ERISA – including its provision allowing a single entity to perform both fiduciary and non-fiduciary functions – has functioned effectively. The competitive market for group insurance prevents insurers who perform claims administration functions from systematically denying claims for benefits. Not surprisingly, the overwhelming majority of benefits claims are approved. And for claims that are initially denied, Department of Labor regulations guarantee each claimant a right to a full and fair internal review, providing further protection for beneficiaries. For insured health-benefit plans, most states accord beneficiaries a right of appeal to an independent medical reviewer. These market pressures and regulatory constraints all operate to ensure that fiduciary claim determinations are not driven by improper considerations, but are made, as they must be, with an eye toward the best interests of the plan as a whole.

For those reasons, the fact that one entity – either an insurer or the employer itself – separately performs both fiduciary and non-fiduciary functions should not trigger heightened judicial review of claim determinations. Where the plan specifies that a fiduciary's claim determination is discretionary, *de novo* or "sliding-scale" review by courts would frustrate ERISA's purpose to achieve uniformity of interpretation, as illustrated by the splintered approaches of courts of appeals on the questions presented in this case. A plan sponsor can reasonably decide that an experienced and qualified fiduciary will be better positioned than a court to evaluate benefits claims consistently and uniformly in the best interests of the plan as a whole and the rest of its participants. Departing from the abuse-of-discretion standard would have adverse consequences for benefit plans by increasing litigation costs and leaving less money available to pay out claims.

Consistent with principles of trust law relied upon by this Court in *Firestone*, a determination by any fiduciary should be reviewed deferentially unless the evidence establishes that the decision was actually infected by an improper consideration, *i.e.*, the fiduciary's own interest rather than the plan's. A claimant could make such a showing by pointing to evidence of bias or corruption on the face of the administrative record. If the claimant demonstrates that an improper motive actually factored into the fiduciary's determination, then the court should conduct an ordinary trust law analysis by weighing that conflict alongside other factors in assessing whether the fiduciary abused its discretion.

ARGUMENT

I. ERISA'S FRAMEWORK PERMITTING A SINGLE ENTITY TO PERFORM FIDUCIARY AND NON-FIDUCIARY FUNCTIONS HAS OPERATED EFFECTIVELY AND FAIRLY

A. As ERISA Expressly Allows, Many Plans Rely On A Single Entity For Both Fiduciary And Funding Purposes

ERISA neither compels employers to establish benefit plans nor restricts the freedom of employers to define the benefits they choose to provide. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Instead, under ERISA "employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). ERISA protects employee benefit plans by providing contractual and procedural safeguards: if an employer elects to establish a benefit plan, ERISA "simply requires [the] plan[] to afford a beneficiary some mechanism for internal review of a benefit denial, 29 U.S.C. § 1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, § 1132(a)." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385 (2002).

ERISA expressly permits a plan fiduciary responsible for evaluating benefit claims to serve as the plan's funding source. 29 U.S.C. § 1108(c)(3) (an individual or entity may "serv[e] as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest"). Under

§ 1108(c)(3), an insurer may assume the dual responsibility of making benefit determinations and paying claims, and an employer sponsoring a self-funded plan likewise may make its own benefit determinations. The provision marks a conscious departure from "from the absolute common law rule against fiduciaries' dual loyalties," and reflects a congressional judgment that "stringent prophylactic rules" should not be erected to prohibit the plan's funding source from making benefit determinations. *Donovan v. Cunningham*, 716 F.2d 1455, 1466-67 (5th Cir. 1983).

Decades of experience show that under tens of thousands of benefit plans administered by entities that fund the plans, such arrangements can provide substantial efficiency benefits for plans. For insured plans, relying on a single company to evaluate and pay benefit claims can reduce administrative costs and allows the insurer to leverage its expertise and familiarity with the terms of a plan. For self-funded plans, an employer can reduce costs by making benefit determinations in-house, rather than contracting with a third party to administer the plan. Although plan sponsors must consider a host of business and legal factors in selecting a fiduciary and funding source, and many choose to divide those responsibilities among different entities, many employers value the cost savings achieved by delegating the functions to a single entity. By achieving efficiencies in plan administration, employers can offer richer benefits to their employees, and avoid the negative impacts on morale and employee retention they inevitably experience when forced to reduce benefits or require

employee contributions simply because administrative costs cannot be adequately controlled.

Because of the efficiency advantages, it is now common for employer-sponsored benefit plans to lodge fiduciary responsibilities in the same entity that funds the plan. *See Guthrie v. Nat'l Rural Elec. Coop. Ass'n Long-Term Disability Plan*, 509 F.3d 644, 650 (4th Cir. 2007) (describing arrangement in which "a plan's administrator is also its funder" as "simple and commonplace" in the industry); *Hall v. UNUM Life Ins. Co.*, 300 F.3d 1197, 1205 (10th Cir. 2002) (noting that "[t]he administrator and the payor are often the same party for many ERISA benefit plans," and declining to depart from ordinary evidentiary rules "whenever the same party is the administrator and payor" because such arrangements are "commonplace").

B. Market Incentives And ERISA Regulations Ensure That Funding Entities Provide Proper Fiduciary Service

1. ERISA's regulatory framework, operating in conjunction with market incentives, both encourages plan formation and ensures that claims are fairly treated. Employer-sponsored long-term disability plans, like the one at issue in this case, cover well in excess of 28 million American workers, who received long-term disability coverage through 191,000 different benefit plans. Those insurers paid more than $7.2 billion in long-term disability insurance claims to more than 500,000 individuals in 2006, a 7.5% increase over benefits paid in the previous year. One-third of those individuals were ineligible for Social Security Disability Insurance. Council for Disability

Awareness, *The 2006 CDA Long-Term Disability Claims Review* 1, 3 (Apr. 2007), *available at* http://www.disabilitycanhappen.org/news/CDA_LTD_Claims_Survey_2006.asp (survey of companies representing over 75% of the commercial disability insurance marketplace in 2006).

2. Although many of those plans confer fiduciary responsibilities on the entity that funds the plan, the market for group insurance and the demands of plan participants effectively ensure that such entities make benefit decisions entirely in the interests of the plans they serve.

a. For insured plans, insurers with fiduciary claims duties have strong disincentives to systematically deny meritorious claims. As the First Circuit has explained, "employers have benefit plans to please employees and, consequently, will not want to keep an overly tight-fisted insurer." *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (2005). If insurers do not administer employee benefit plans to the actual benefit of employees, employers will simply retain other insurers to insure and administer the benefits. The market for group insurance is highly competitive, particularly for large employers like Sears, Roebuck and Company. Many employers renegotiate the terms of their insured benefit plans annually or biannually. They frequently issue requests for proposals, entertain bids from multiple insurers, and engage in extensive negotiation over the terms of the plan. Because employers who sponsor benefit plans "have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims," a practice of denying

claims improperly ultimately "would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers." *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998).

Market forces, in short, provide "an important competing motive" that minimizes the risk that an insurer will wrongfully deny claims to save money in the short term. *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998). Ignoring the effect of those forces, the Government incorrectly assumes that an insurer who provides fiduciary claims administration services will consider each transaction in isolation, seeking to "fill[] . . . its coffers" immediately. U.S. Cert. Br. 13. Any such insurer will not be in the business of insuring employee benefit plans for long. The Government's assumption also misapprehends the business of insurance. Insurers make money *not* by routinely denying claims, but by making careful actuarial predictions about potential liabilities, assuming that claims *will* be paid, and managing costs and risks on that basis. *See* Barry D. Smith & Eric A. Wiening, How Insurance Works 3-4, 8-9 (2d ed. 1994). The obligation to pay out claims, in other words, is an assumed and necessary function in the provision of insurance services.

b. Market incentives operate even more directly for self-funded plans. Whereas employers may insist that insurers administer benefits fairly to satisfy employees, when the employer itself is the fiduciary, the employer must respond directly to the expectations of the employees it wants to satisfy and the workforce it wants to attract and retain. It would be

"a poor business decision to make it a practice of resisting claims for benefits" because "[i]n the long run, such a practice would dampen loyalties of current employees while hindering attempts to attract new talent." *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995); *see Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1051 (7th Cir. 1987). By expressly permitting corporate officers to serve as plan fiduciaries, ERISA embodies a reasonable congressional judgment that "[t]he impact on a company's welfare of granting or denying benefits under a plan will not be sufficiently significant as to threaten the administrators' partiality." *Chalmers*, 61 F.3d at 1344.

c. Unsurprisingly, the foregoing market incentives have significant effects on plan benefit decisionmaking. Contrary to some popular lore, the overwhelming majority of employee benefit coverage claims are granted. A study of claims submitted in 2002 to health plans representing 26 million persons showed that 86 percent of all claims submitted were granted. Health Ins. Ass'n of America, *Results from an HIAA Survey on Claims Payment Processes* 10 (March 2003), *available at* www.ahipresearch.org/PDFs/21_ClaimsPaymentProcessesSurveyChartbook.pdf. And of the 14 percent that were denied, 48 percent were denied because they were duplicate submissions, and 20 percent were denied because the individual was no longer covered or the policy had lapsed. *Id.* at 10. Only about 3 percent of all claims were denied on the ground that the asserted benefit was not covered by the plan, 0.4 percent were denied for eligibility reasons, and one percent of claims were denied for other reasons. *Id.* There is simply no evi-

dence that employers and insurers are driven by self-interest to deny claims routinely – just the opposite is true.

3. Not all claims are granted, of course. But even when claims are initially denied, ERISA regulations requiring internal plan review ensure that claimants have an effective means of challenging the denial. ERISA requires that employee benefit plans provide effective notice of coverage denials and a reasonable opportunity for "full and fair review" of such decisions.[2] The Department of Labor has promulgated comprehensive regulations governing the appeal process. *See* 29 C.F.R. § 2650.503-1(h). The regulations compel benefit plans to establish and maintain a procedure under which there is an opportunity for full and fair internal review. *Id.* § 2650.503-1(h)(1). To satisfy the regulations, the review must take into account "all comments, documents, records, and other information submitted by the claimant relating to the claim," *id.* § 2560.503-1(h)(2)(iv), and must be conducted by someone other than the initial reviewer, with no deference to the initial decision, *id.* § 2560.503-1(h)(3)(ii). In cases involving the exercise of medical judgment, the plan administrator must consult with a health care professional in the rele-

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[2] *See* 29 U.S.C. § 1133(1) (requiring that plans "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reason for such denial, written in a manner calculated to be understood by the participant"); *id.* § 1133(2) (requiring that plans "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim").

vant field when conducting its review. *Id.* § 2560.503-1(h)(4). And in every case, the reviewer must provide a written explanation of the final decision with specific reference to pertinent plan provisions. *Id.* § 2560.503-1(j)(1).

Notably, when the DOL amended its regulations in 2001 to provide for this comprehensive internal review structure, it did *not* require sponsors to name a plan fiduciary distinct from the plan's funding source. *See* 66 Fed. Reg. 35887 (July 9, 2001) (codified at 29 C.F.R. pt. 2560).

The internal plan review guaranteed by DOL regulations provides significant protection for plan beneficiaries. Employer-sponsored health plans review more than 250,000 internal appeals annually. *See* David M. Studdert & Carol Roan Gresenz, *Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations*, 289 J. Am. Med. Ass'n 864, 864 (2003). One leading study of health plans showed that plan fiduciaries granted benefits in approximately 42 percent of appeals. *Id.* at 866; *see also* AAHP, *Independent Medical Review of Health Plan Coverage Decisions* 1 (2001), *available at* http://www.ahip.org/content/default.aspx?bc=38|82|2246 (estimating that 49% of appeals in health plans result in grant of benefits).

Moreover, in *Rush Prudential*, this Court held that states could provide external review for health-benefit plan determinations (so long as such review did not act more like arbitration than a medical "second opinion"). 536 U.S. at 359. Consistent with that holding, forty-three states and the District of Columbia have external review programs that allow

beneficiaries to appeal denials of coverage. AHIP Center for Policy and Research, *Update on State External Review Programs* 2 (Jan. 2006), *available at* http://www.ahipresearch.org/pdfs/External_Reviews-Jan06.pdf. Those programs provide substantial additional protection for plan beneficiaries. *Id.* at 1, 6-7.

* * *

In sum, market incentives and regulatory protections together operate to ensure that plan benefit decisions are neither arbitrary nor self-interested. Absent evidence that bias or corruption influenced the process, there is no basis for judicial intervention into the plan administration process. To the contrary, such intervention would affirmatively undermine ERISA's objectives and the interests of plan beneficiaries, as the next section demonstrates.

II. A BENEFIT DETERMINATION BY AN ENTITY THAT ALSO FUNDS THE PLAN SHOULD NOT BE PRESUMPTIVELY SUBJECT TO HEIGHTENED JUDICIAL REVIEW

Where a plan specifies that a fiduciary's claim determination is discretionary, courts should not presume that *de novo* or "sliding-scale" or reasonableness review is appropriate merely because the fiduciary is also employed by or associated with the plan's funding source. Heightened judicial review of discretionary determinations by a plan fiduciary would frustrate ERISA's purpose of achieving uniformity and predictability in the oversight of benefit plans, and it would increase litigation costs by encouraging every individual whose claim is denied to

seek a second opinion in court. Instead, consistent with this Court's decision in *Firestone*, and with principles of trust law on which ERISA is predicated, reviewing courts should give no weight to a fiduciary's potential conflict in the absence of a showing that an improper consideration actually affected the decision.

A. Heightened Judicial Scrutiny Of Benefit Decisions By Entities Who Fund Plans Would Undermine ERISA's Purposes And Have Adverse Consequences For Benefit Plans

1. ERISA was designed "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). To that end, ERISA "sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility," and it preempts most contrary state-law provisions. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *see* 29 U.S.C. § 1144(a). A single federal standard was "desirable," Congress concluded, "because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state." H.R. Rep. No. 93-533, at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650.

Congress also recognized the interest of employers in the uniform interpretation and application of their benefit plans. Many large employers provide plans that extend to beneficiaries in multiple jurisdictions, and such plans would be threatened if they were "subject to different legal obligations in different States." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148

(2001). Consistent with its purpose to ensure "nationally uniform plan administration," ERISA therefore "require[s] that plans be administered, and benefits be paid, in accordance with plan documents." *Id.* at 148, 150.

A rule that subjects the decisions of fiduciaries with potentially conflicting interests to *de novo* or otherwise heightened judicial review would undermine ERISA's purpose of ensuring uniformity in the interpretation and administration of benefit plans. Instead of a single fiduciary, chosen by the plan settlor and vested with discretion in making benefit determinations, every federal district court would have authority to second-guess benefit determinations by reweighing the evidence and construing the plan documents. Because courts entertain only one case at a time, they would have no obligation to respect the fiduciary's decisions concerning similarly situated claimants or to consider the consequences of a decision for other beneficiaries. *See Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1006 (4th Cir. 1985) (deferential review "exists to ensure that administrative responsibility rests with those whose experience is daily and continual, not with judges whose exposure is episodic and occasional"). This Court recently made a similar point (albeit in a different context) about the limited capacity of decisionmakers in case-by-case adjudication, compared with those charged with taking a broader view. *See Riegel v. Medtronic, Inc.*, No. 06-179 (Feb. 20, 2008), slip op. 11-12 ("A jury, on the other hand, sees only the cost of a more dangerous design, and is not concerned with its benefits; the patients who reaped those benefits are not represented in court."). And because

district courts would seldom be bound by precedent in interpreting the terms of a plan, they would be free to adopt constructions that conflict with those of other courts or the plan administrator. Indeed, the risk of inconsistent interpretations is among the reasons that plan settlors choose to give the fiduciary discretionary authority to interpret the plan. *See Firestone*, 489 U.S. at 111 (noting that "[a] trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable") (citing Bogert & Bogert, Law of Trusts and Trustees § 559, at 169-71 (2d rev. ed. 1980)).

The splintered decisions of courts of appeals on the questions presented in this case illustrate the potential for inconsistency when federal courts – contrary to the wishes of the plan sponsor – conduct *de novo* or "sliding scale" or reasonableness review of benefit determinations because of a potential conflict of interest. Even courts that have *agreed* on the existence of a relevant conflict of interest have differed sharply as to how that conflict affects the standard for reviewing the claim. *Compare* Pet. App. 10a (potential conflict must be weighed alongside other factors when reviewing for abuse of discretion); *with Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000) ("sliding scale" review depending on nature of conflict and other circumstances); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (5th Cir. 1999) (same); *and Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000) (*de novo* review). Appellate courts also have fractured over the claimant's ability to introduce new evidence before the reviewing court, *see*

Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 967 (9th Cir. 2006) (en banc), the burden of proof and persuasion in cases involving a potential conflict, *see Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004), and the circumstances, if any, in which a claimant may obtain discovery, *see Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 814-15 (7th Cir. 2006), *cert. denied*, 127 S. Ct. 53 (2006). Such procedural differences abound at the district court level, and an employer seeking predictability in the administration of its benefits plan should have the ability, consistent with the purposes of ERISA, to obtain uniformity in the review of its benefits determinations by vesting discretion in a fiduciary of its choice.

2. Another central purpose of ERISA is to avoid "creat[ing] a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). ERISA and its accompanying regulations were designed to promote the internal resolution of claims and to encourage non-adversarial proceedings, minimizing "both the likelihood of subsequent federal litigation and the costs that would be attendant thereto." *Jewell v. Life Ins. Co. of N. Am.*, 508 F.3d 1303, 1308 (10th Cir. 2007).

Heightened judicial review of benefit determinations in cases involving an entity with both fiduciary claims responsibilities and non-fiduciary funding obligations would be inconsistent with that purpose because it would increase litigation and administrative costs in three ways. First, non-deferential review would encourage every individual with a borderline

claim denied by such an entity to seek a second opinion in federal court, directly contrary to ERISA's objective to promote internal resolution of claims. Second, even individuals with weak claims would have a stronger incentive to file a lawsuit in the hope of obtaining a favorable settlement. Third, nondeferential review would increase the likelihood of reversal, even in cases where the fiduciary acted reasonably. As a result, plans would be forced to spend more money, both to defend against the greater volume of litigation and to pay out claims properly denied by the fiduciary in the reasonable exercise of its discretion, as contemplated by the plan. Employers might respond to those costs in various ways – by reducing the available coverage, paying increased premiums, or discontinuing the plan entirely – but none of them would redound to the benefit of plan participants in the long run.

This Court in *Firestone* acknowledged the possibility "that a *de novo* standard would encourage more litigation" and drive up costs, and emphasized that parties are free to choose a standard of review based on those considerations. 489 U.S. at 114-15. In this case, and under tens of thousands of similar employer-sponsored plans, the employer has voluntarily chosen to vest a single entity with the duty to make benefit determinations and the responsibility to pay claims. That arrangement is expressly permitted by ERISA, and many employers prefer it, notwithstanding the potential conflict of interest, because it improves plan efficiency and thereby conserves plan funds. *See supra* at 7-8. Imposing nondeferential review on the benefit determinations of all entities with funding obligations not only would

contravene one of the central purposes of ERISA, but would frustrate the objectives of employers who made the considered judgment that vesting both responsibilities in a single entity would maximize the resources available to provide plan benefits. *Id.*

B. Courts Should Give No Weight To A "Potential Conflict" In The Absence Of A Showing That The Benefits Decision Was Infected By An Improper Consideration

In rare circumstances, a fiduciary's *potential* conflict of interest may develop into an *actual* conflict of interest that "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). Before the conflict is entitled to any weight, however, a claimant must make a substantial showing that the potential conflict actually infected the challenged benefit determination.

1. When a benefit plan confers discretion on the plan administrator to determine benefit eligibility, a court's power to review coverage decisions is highly circumscribed. As the Court explained in *Firestone*, principles of trust law guide the application of ERISA in this context, and under those principles when "discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion." 489 U.S. at 111 (quoting Restatement (Second) of Trusts § 187). A court "*will not interfere* to control [trustees] in the exercise of a discretion vested in them by the instrument under which they act." *Id.* (quoting *Nichols v. Eaton*,

91 U.S. 716, 724-25 (1875) (emphasis altered)). In the law of trusts, "[t]he cases are numerous in which it has been held that where discretion is conferred upon the trustee with respect to the exercise of a power the court will not interfere with him in his exercise or failure to exercise the power so long as he is not guilty of an abuse of discretion." 3 Scott & Fratcher, The Law of Trusts § 187 (4th ed. 1988).

The same trust principles relied upon by the Court in *Firestone* provide clear guidance as to when and how a conflict of interest affects the abuse-of-discretion analysis. As the Restatement (Second) of Trusts explains:

> The court will control the trustee in the exercise of a power . . . where he acts from a motive other than to further the purposes of the trust. Thus, if the trustee in exercising or failing to exercise a power does so . . . to further some interest of his own or of a person other than the beneficiary, the court will interpose. *Although ordinarily the court will not inquire into the motives of the trustee, yet if it is shown that his motives were improper or that he could not have acted from a proper motive, the court will interpose.*

Restatement (Second) of Trusts § 187 cmt. g (emphasis added). A potential conflict of interest is only a fact "to be considered" in determining whether the trustee was *actually* motivated by the conflict – the relevant question when evaluating whether the trustee abused its discretion. *Id.*; *accord* Restatement (Third) of Trusts § 50(1) cmt. b (2003) (in reviewing discretionary decisions by a trustee, "[c]ourt inter-

vention may be obtained to rectify abuses *resulting from* bad faith or improper motive") (emphasis added).

This principle of trust law supports the approach of those appellate courts holding that the review of a plan administrator's discretionary eligibility determination remains fully deferential, even when the administrator is also the plan's funding source, unless and until the claimant produces specific evidence (beyond the conflict itself) establishing that the non-fiduciary funding obligation role actually affected the fiduciary's judgment. *See Pulvers*, 210 F.3d at 92 (an insurer's role as plan administrator "is alone insufficient as a matter of law to trigger stricter review," and the claimant must produce "evidence that [its] decision was actually affected by a conflict of interest"); *Buttram v. Central States, Se. & Sw. Areas Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996) ("[A]bsent material, probative evidence, beyond the mere fact of the apparent [conflict of interest], tending to show that the administrator breached his fiduciary obligation, we will apply the traditional abuse of discretion analysis to discretionary trustee decisions." (citations omitted)). The bare fact that the same entity serves as the funding mechanism and evaluates benefit claims – an arrangement explicitly allowed by statute and intended by the plan sponsor – is entitled to no weight in determining whether the fiduciary abused its discretion.

2. To establish an actual conflict of interest relevant to judicial review of a benefit determination, a claimant should be required to make a threshold showing of bias or corruption based on the adminis-

trative record. *See Rush Prudential*, 536 U.S. at 384 n.15 (under *Firestone*, a conflict of interest affects the abuse-of-discretion standard only if "plausibly raised"). The terms of the plan itself, for example, may create a prima facie inference of bias. *See Pegram v. Herdrich*, 530 U.S. 211, 227 n.7 (2000) (offering the example of a plan that provides "a bonus for administrators who denied benefits to every 10th beneficiary"); *Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 31 n.15 (1st Cir. 2006) (addressing question whether insurer "intentionally set up a biased process"). The claim file may also reveal a complete abdication on the part of the plan administrator, as in a case where the decisionmaker failed to consult any relevant evidence, which can give rise to an inference that the administrator acted pursuant to an improper consideration. *See* Restatement (Second) of Trusts § 187 cmt. h (the court will interpose where the exercise of a power "is left to the judgment of the trustee and he fails to use his judgment," as in a case where the trustee acts "without knowledge of or inquiry into the relevant circumstances and merely as a result of his arbitrary decision or whim"). In that situation, however, the proper course for a court should be to remand the decision to the plan for reconsideration by the plan fiduciary in accordance with proper procedures, including the full and fair internal review required under DOL regulations, as discussed above, *supra* at 12-13. *See, e.g.*, *Buffonge*, 426 F.3d at 31-32; *Smith v. Cont'l Cas. Co.*, 450 F.3d 253, 265 (6th Cir. 2006); *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 477-78 (7th Cir. 1998). The question whether a decision was infected by an improper consideration should be asked only after the decision has been

properly made in accordance with appropriate internal review procedures.

A contrary rule that presumes bias or corruption on the part of every fiduciary employed by a plan funding source, or that allows plaintiffs to conduct discovery into the fiduciary's motives without any concrete basis in the administrative record, would significantly increase litigation costs for benefit plans, contrary to the purposes of ERISA. *See Jewell*, 508 F.3d at 1308 ("[c]onfining review in general to the administrative record . . . is important for a variety of reasons related to the goals of ERISA," including the minimization of litigation costs). As the Seventh Circuit has explained, "onerous discovery before an ERISA claim can be resolved would undermine one of the primary goals of the ERISA program: providing 'a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously.'" *Semien*, 436 F.3d at 815 (quoting *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990)). For that reason, discovery must be "limit[ed] . . . to those cases in which it appears likely that the plan administrator committed misconduct or acted with bias." *Id.* at 816. The bald assertion of a potential conflict of interest arising from a fiduciary's association with the plan's funding mechanism cannot suffice to justify such discovery – "specific factual allegations of misconduct or bias in a plan administrator's review procedures" must be required. *Id.* at 815-16.

Even in the rare case in which a claimant establishes that the plan administrator acted pursuant to an actual conflict of interest, *Firestone* makes clear that a court should not adopt a different standard of

review. Instead, the conflict "must be weighed as a 'facto[r] *in determining whether there is an abuse of discretion.*'" *Firestone*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (alteration in original, emphasis added); *Rush Prudential*, 536 U.S. at 384 n.15 (explaining that under "*Firestone Tire* itself," "any conflict of interest on the plan fiduciary's part," if "plausibly raised," would affect "review for abuse of discretion"). The ultimate inquiry is whether the fiduciary "act[ed] beyond the bounds of a reasonable judgment," not whether "the court would have exercised the [discretionary] power differently." Restatement (Second) of Trusts § 187 cmts. e, i. Accordingly, a fiduciary's determination should be affirmed, notwithstanding an actual conflict of interest, if it is supported by substantial evidence such that a reasonable person could have reached the same conclusion. *See, e.g.*, *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1179 (8th Cir. 2001); *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 382 (10th Cir. 1992).

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

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Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY), ET AL.,
Petitioners,
v.
WANDA GLENN,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF FOR THE BLUE CROSS AND BLUE SHIELD ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER

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INTEREST OF THE AMICUS CURIAE

The Blue Cross and Blue Shield Association ("BCBSA") is the national association of Blue Cross and Blue Shield companies. It comprises thirty-nine independent, locally owned Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield companies, through relationships with federal, state, and local government entities, employers, employee benefits plans, and individual subscribers, administer or insure health benefits for nearly 100 million Americans. In most instances, the provision of these benefits is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*[1]

This case involves the appropriate standard of review in actions for judicial review of an ERISA plan administrator's discretionary benefits determination. More specifically, the Petition for Certiorari presents the question whether an ERISA plan administrator that both adjudicates and pays claims is operating under a conflict of interest that must be weighed on judicial review of a discretionary benefits determination. In granting the Petition, the Court additionally asked the parties to address the question of how any such conflict of interest should be taken into account on judicial review, in the event the Court does deem the conflict to exist.

As entities that administer and insure ERISA health benefits, Blue Cross and Blue Shield

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[1] In accordance with Rule 37.6, BCBSA certifies that counsel for a party did not author this brief in whole or in part and that no entity other than BCBSA, its members, or its counsel made a monetary contribution to the preparation or submission of the brief.

companies often have responsibility for both adjudicating and paying claims for benefits. Indeed, some of the decisions identified in the Petition that analyze the existence and effect of any perceived conflict of interest on the part of ERISA plan administrators adjudicating and paying claims have involved Blue Cross and Blue Shield entities. *See* Pet. 9-10; *see, e.g., Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990). Accordingly, BCBSA's members have a strong interest in how the Court resolves the question whether ERISA plan administrators that both adjudicate and pay claims operate under a conflict of interest and how any perceived conflict is taken into account (if at all) on judicial review of a discretionary benefits determination.

Counsel for Petitioner has submitted a letter to the Clerk of the Court consenting to the filing of all *amicus* briefs in this case. Counsel for Respondent has consented to the filing of BCBSA's *amicus* brief, as evidenced in the letter from Respondent's counsel accompanying this brief.

SUMMARY OF ARGUMENT

A. An ERISA plan administrator that both adjudicates and pays claims does not, merely because of that dual role, operate under a conflict of interest. Congress, through exceptions to ERISA's prohibited transaction rules, has permitted fiduciaries additionally to take on non-fiduciary functions. Treating plan administrators who occupy the dual roles of paying and deciding claims -- without more -- as somehow indicative of a conflict of interest is in tension with Congress's allowance for dual roles.

Nor does an assumed conflict of interest take account of the complexities or market realities of insurance. Using health insurance as an example, insurance can be, among innumerable other options, retrospectively rated, accompanied by reserves that balance risk, and experience rated -- all of which help negate the idea that a denied claim will automatically result in additional funds for an insurer. And market pressures, such as the need to satisfy employers who purchase their products, shield against insurers arbitrarily denying meritorious claims. Similarly, in plans where an employer self-funds (or self-insures) benefits, the employer may re-insure its risk or purchase stop-loss coverage, meaning that claims paid do not necessarily result in additional cost to it. The need to satisfy employees by providing promised benefits is also an overriding factor working in favor of an employer seeking to pay claims based on merit rather than denying them based on some purported financial interest.

Moreover, the courts have not found conflicts of interest in non-ERISA situations, where the claims decision-maker in some theoretical way stands to gain from a claims denial. In federal employee health benefits plans and under the Social Security and Medicare programs, the government makes final claims determinations, and claims denials can conserve the government's own funds or at least funds over which it is trustee. Yet, the courts have not perceived a conflict of interest and instead have deferred to agency decision-making because (as can be said in the ERISA situation as well) the decision-maker has valuable experience on interpretive issues.

B. Even if the Court deems a conflict inherent in a plan administrator's dual role, it should not adopt any special construct on judicial review to address such a conflict. ERISA already contains many safeguards against a plan administrator acting on the supposed conflict of interest. These safeguards include: rules requiring fiduciaries entering engagements with service providers (such as insurers) to examine the service providers' operational procedures; fiduciary obligations that preclude action based on self-interest and that are enforceable through powerful remedies; and regulatory claims requirements designed to ensure the full and fair review of claims.

Additionally, no special construct is necessary on judicial review because the customary abuse-of-discretion standard already captures all of the likely infirmities that decision-making based on conflicts of interest might be expected to engender. And finally, the Court should reject any special construct for judicial review of decisions by plan administrators with a dual role, given that the heightened scrutiny would prove difficult to apply. The complications heightened scrutiny would add to routine ERISA cases are not worth enduring, particularly given that the perceived conflict is more imagined than real.

ARGUMENT

I. AN ERISA PLAN ADMINSITRATOR THAT BOTH ADJUDICATES AND PAYS CLAIMS DOES NOT, MERELY BECAUSE OF THAT DUAL ROLE, OPERATE UNDER A CONFLICT OF INTEREST

The Circuit split on the questions before the Court has its genesis in *dictum* from *Firestone Tire*

& Rubber Co. v. Bruch, 489 U.S. 101 (1989), regarding the appropriate standard of review in actions for judicial review of discretionary ERISA benefits determinations. In *Firestone*, the Court held that "a denial of benefits challenged under [ERISA] . . . is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case abuse-of-discretion review applies. *Id.* at 115. Though the Court ultimately directed *de novo* review in the controversy before it, the Court in *Firestone* then added instructions on consideration of an ERISA decision-maker's potential conflicts of interest under the abuse-of-discretion standard: "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d at 403 (1959)).

The Court's *dictum* in *Firestone* has, of course, led the Circuits to examine whether an ERISA plan administrator that both adjudicates and pays claims acts under a conflict of interest and, if so, how to take such a conflict into account. The answers to these questions have ranged from some Circuits concluding that the administrator's dual role does not result in a conflict of interest (*e.g.*, *Wright v. R.R. Donnelly & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999)), to other Circuits holding that it always does and that an elaborate shifting of

burdens of persuasion (*see Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990)) or "sliding scale[s]" of scrutiny must follow. *Abatie v. Alta Health & Life Ins. Servs., Inc.*, 458 F.3d 955, 968 (9th Cir. 2006).

The correct answer to the threshold issue -- *i.e.*, whether a conflict of interest exists in the first place -- is that there is no conflict of interest when an ERISA plan administrator both adjudicates and pays benefits. ERISA's structure and terms do not support recognition of a conflict; deeming a conflict to exist does not comport with the market realities of insurance or self-funded plans; and the courts have not found conflicts of interest in the context of non-ERISA benefits programs, where a decision-maker has some connection to the entity responsible for paying benefits.

A. ERISA's Terms and Structure Do Not Contemplate the Finding of a Conflict of Interest

From ERISA's inception, Congress knowingly authorized the duality of settlor and fiduciary functions in single entities, an authorization inconsistent with a finding that the duality inevitably constitutes a conflict of interest. In its most simple form, a conflict of interest is a "real or seeming incompatability with one's private interests and one's public or fiduciary interest." *Black's Law Dictionary* 319 (8th ed. 2004). Certainly, Congress saw no such incompatibility between an ERISA plan's obligations to pay benefits and its administrator's fiduciary duty to adjudicate benefits claims properly.

In enacting ERISA, Congress, of course, sought to protect ERISA plan participants and their beneficiaries. *See Varity Corp. v. Howe*, 516 U.S. 489, 496 (1996). ERISA imbued standards of conduct and oath-like, professional obligations upon fiduciaries, while establishing an intricate network of remedies and sanctions for prohibited behavior and transactions. ERISA gives plan participants direct access to federal judicial review of potential controversies. One path to this review is through 29 U.S.C. § 1132(a)(1)(B), which permits a plan participant to bring a civil action to allege that benefits due have been denied. The plan participant also has the right to bring a civil action to allege a breach of fiduciary duty, under 29 U.S.C. § 1132(a)(2) and potentially under 29 U.S.C. § 1132(a)(3).

A particular facet of the ERISA regime is that it contains a detailed set of rules concerning prohibited transactions and an equally detailed set of exceptions to those rules. *See id.* §§ 1106, 1108. ERISA, in 29 U.S.C. § 1108(c)(3), makes a specific exception to allow a fiduciary to serve as an officer, employee, agent, or other representative of a party in interest while serving as a fiduciary. The legislative history notes that Congress permitted this "in recognition of established business practices. Thus a fiduciary could receive his normal benefits as a participant under the plan, could receive reasonable compensation for services and for reimbursement of actually incurred expenses, and could be an officer, agent or employee of an interested party." Staff of the Joint Comm. on Internal Revenue Tax'n, 93d Cong., *Summary of*

Proposal for Private Pension Plan Reform, at 24 (Comm. Print 1973).

The legislative history also notes: "The committee may wish to allow exemptions to be granted by the Secretaries of Labor and Treasury (jointly) only where needed so as to not unduly disrupt the established business practices of financial institutions (such as commercial banks, trust and insurance companies, and investment counsellors), which often perform fiduciary functions in connection with employee benefit plans." *Id.* at 55. This reason is mentioned again in a Senate Finance Committee Report, where the definition of a "party in interest" is also defined as:

> (1) managers (and employees) of the plan, (2) persons providing benefit plan services to the plan, (3) the employer and its officers, directors and highly compensated employees, and controlling or controlled parties, or parties under common control, (4) employee organizations (e.g., labor unions, including the national and international unions where a plan covers any local) with members covered by the plan, and officers and directors of those organizations and (5) fiduciaries who benefit other than in their capacity as plan fiduciaries from the particular prohibited transaction.

S. Rep. No. 93-383, at 100, 103 (1973).

Hence, Congress acknowledged the relationship a fiduciary may have to an interested party and approved of the dual role, which Congress acknowledged was an established business practice.

In its deliberation over exemptions to the prohibited transaction rules and how they might be established, there is no indication that Congress was concerned about this duality that it acknowledged existed. The duality is never even referred to as a conflict in a section of the legislative history that addresses conflicts of interest and fiduciaries:

> Transactions primarily involving conflicts of interest and fiduciaries --
>
> > The committee bill generally prohibits a fiduciary from dealing with the income or assets of a trust in his own interest or for his own account. However, this does not prohibit the fiduciary from dealings where he has an account in the employee benefit trust and the dealings apply to all trust accounts without discrimination.
> >
> > The bill also prohibits fiduciaries from receiving consideration in connection with a transaction involving the trust from any party who deals with the trust. This prevents, e.g., kickbacks to a fiduciary.

S. Rep. No. 93-383, at 99.

In the end, Congress implemented safeguards throughout ERISA to protect participants from actual conflicts of interest, safeguards that we point out later. *See supra* pp. 26-29. But Congress had little difficulty, and saw no conflict, in connection with a fiduciary also having non-fiduciary interests under an ERISA plan. The Court should not now

treat as an inherent, and suspicious, conflict of interest the dual role that Congress accepted.[2]

B. Deeming a Conflict to Exist Does Not Comport with the Market Realities of Insurance or Self-Funded Plans

The view that an ERISA plan administrator both adjudicating and paying benefits, without more, operates under a conflict of interest derives from an overly simplistic approach to insurance and plan funding and does not take into account how plans actually operate in the market. Under this view, the core postulates are that a plan administrator "incurs a direct expense as a result of the allowance of benefits, and it benefits directly from the denial or discontinuation of benefits." *Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (6th Cir. 1998); *accord Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 437 (3d Cir. 1997). But such conclusions miscomprehend how insurance companies make money and disregard an employer's purpose in providing benefits. The *amicus*'s members are principally in the business of providing or facilitating the provision of health benefits; we therefore here focus particularly on the market realities and incentives associated with health insurance and the funding of health benefits.

ERISA health benefits plans can be either insured or self-funded. *See generally FMC Corp. v.*

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[2] ERISA can also take its cue from trust law. *See Varity*, 516 U.S. at 496. But even well-settled trust principles cannot override Congress's intent in ERISA. *Id.* at 497. In any event, Petitioner has ably shown that presuming a conflict in these circumstances is inconsistent with trust principles. *See* Petitioner's Br. at 23-26.

Holliday, 498 U.S. 52, 54 (1990). In both insured and self-funded plans, a single entity may be both the final decision-maker on claims and the payer of benefits. With insured plans, the employer decides to sponsor a plan and contracts with an insurance company (as permitted by ERISA; *see* 29 U.S.C. § 1002(1)) to bear the financial risk, process claims, and typically to make final benefits determinations upon appeal. In self-funded plans, the employer designs the plan and determines what benefits to cover, maintains some or all of the financial risk, and often hires a third-party administrator ("TPA") to process claims. *See* John C. Garner, *Health Insurance Answer Book*, Q 17:4, 17-2 and 17:11, at 17-4 (7th ed. 2006). In the typical self-funded arrangement, the employer will commonly establish a benefits committee to make final benefits determinations upon appeal. Even though the insurance company in an insured arrangement or the employer in a self-funded arrangement is ultimately responsible for making final claims determinations and paying benefits, neither would be acting in its *own* best interest by denying meritorious claims. In fact, the opposite is true: both have direct incentives to ensure that meritorious claims are paid.

1. *Insured Plans*. The decision to pay or deny an individual claim, even a large claim, is unlikely to affect the financial health of an insurance company. As a threshold matter, because many U.S. insurance companies today are multi-million or even multi-billion dollar [illegible] "the award in any one case will have only [illegible] effect on [the insurer's] operation[al] results." *Perlman v. Swiss Bank Corp.*

Comprehensive Disability Prot. Plan, 195 F.3d 975, 981 (7th Cir. 1999).

More fundamentally, the "indispensable characteristic of insurance" is the "spreading and underwriting of a policyholder's risk." *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 127 (1982) (internal quotation marks omitted). For an insured benefit plan, the risk is spread across all covered members. The effect of risk distribution dilutes the impact of any specific claim and virtually eliminates self-interest based on the outcome of individual claims. "It is [a] characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it." 1 G. Couch, *Cyclopedia of Insurance Law* § 1:3 (2d ed. 1959).

Furthermore, under the risk-sharing designs and other pricing features currently prevalent in the insurance market, it is simply untrue that an insurance company has a financial incentive to deny claims. For instance, many plans are designed with retrospective rating. *See Perlman,* 195 F.3d at 981. Under these arrangements, the policyholder pays an estimated premium throughout the year, and at the end of the year, if claims paid were less than predicted, a certain percentage will be paid back to the employer. *See* Garner, *Health Insurance Answer Book,* Q 5:15, at 5-6. Conversely, if claim costs are more than predicted, the employer will owe an additional amount to the insurance company at the end of the year. *Id.* In such situations, it is the employer -- an entity not responsible, in the insurance context, for adjudicating claims -- that

may financially benefit from lower than anticipated claims payments or suffer financial loss from greater than anticipated claims payments.

Other arrangements may leave the risk of loss principally with the insurer, but set up a rate-stabilization reserve to "help offset the cost of a particularly bad year" and avoid "an otherwise large increase [that] might be called for at the next renewal." *Id.*, Q 5:18, at 5-8. The amounts necessary to establish a rate-stabilization reserve are figured into the premium calculations. With a rate-stabilization reserve, the insurer has diminished potential for a loss in the event it pays a claim, since the reserve may be available to cover the claim if the premium funds otherwise run out.[3]

Still another pricing feature illustrating that an insurer has no financial incentive to deny claims is experience rating. Under experience rating, an employer's premium rates are set based on the employer's own past claims experience. Garner, *Health Insurance Answer Book*, Q 5:24, at 5-9. As a result, the payment of fewer claims than expected lowers the following year's premiums and thus over time will decrease the insurer's funds. In this sense, the consequence of the denial of otherwise meritorious claims can be lower future premium income for the insurer.

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[3] In a fully insured plan, even without a rate-stabilization reserve, it can be expected that, if more claims were paid than anticipated, those funds might simply be recaptured the following year through a premium rate increase charged to the employer. Again, the consequence is that the payment of a claim does not inevitably translate into a loss for the insurer.

Not only do the complex features and pricing of modern-day insurance undermine the notion that insurers will make more money if they deny claims, the market protects against unwarranted claims denials. The U.S. insurance market is a highly competitive one. *See Rud v. Liberty Life Assurance Co. of Boston*, 438 F.3d 772, 775 (7th Cir. 2006). In the competitive environment, a reputation for "tight-fisted[ness]" is not a badge of honor for an insurance company. *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005). As the First Circuit has explained, employers "desire[] to please their employees" through the ERISA plans they create. *Id.* at 75; *see also Chojnacki v. Georgia-Pac. Corp.*, 108 F.3d 810, 815 (7th Cir. 1997). If an insurer has a poor record of accuracy on claims payment, the employees will become disgruntled, and the employer will take its business elsewhere. *See Rud*, 438 F.3d at 775.[4]

As a final note on insured plans, to assume the person or department responsible for making claims determinations at an insurance company has responsibility for -- or is even cognizant of -- the company's budget is far-fetched. Insurance companies are large, complex, often multi-state or

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[4] It is also worth emphasizing that insurance companies are highly regulated entities. Under ERISA, the states largely retain their traditional role of regulating the business of insurance. *See* 29 U.S.C. § 1144(b)(2) ("[N]othing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ."). Thus, not only would the market ensure against financially motivated denials of benefits, state regulators can be expected to seek to do the same.

even international entities. Unless the actual decision-making individuals have tangible incentives to act solely with an eye toward the company's bottom line, there is no reason to expect they would deny claims based on the company's self-interest. Indeed, quite to the contrary, companies have as much incentive to provide employees with bonuses for claim processing accuracy. They may do so because, among other reasons, inaccurate claims adjudication can (as mentioned) harm the insurer's reputation and, therefore, its competitive position. Inaccurate claims adjudication also ultimately can prove costly, for a claim denied without sound reason is more likely to be challenged in court, and the cost of litigation can often dwarf the benefits amount at issue.

In sum, a conflict of interest assumes there is a force separate from the merits pushing the conflicted party in a different direction. No such force is present with insurance. The structure of insured plans in today's market does not result in financial incentives to deny meritorious claims, but instead encourages accurate claims payment. Accordingly, there is no conflict of interest when the insurance company is both the adjudicator and payer of claims.

2. *Self-Funded Plans*. In a self-funded (or self-insured) plan, the employer acts as self-insurer and retains the risk in lieu of transferring it to an insurance company. *See FMC Corp. v. Holliday*, 498 U.S. at 54. The employer will often hire a TPA (which is permissible under ERISA's prohibited transaction rules, *see* 29 U.S.C. § 1108(b)(2)), that will process claims for a fee, but final claims decisions are usually decided by a committee established by the employer. Therefore, the

employer can be both the claims payer and final decision-maker, just as with an insurance company is in an insured arrangement.

In a self-funded plan, there is no financial incentive for the employer to act differently than the merits of the claim would require, and thus no conflict of interest. One of the primary reasons employers provide employee benefits is to assist with recruitment and retention. *See* 29 U.S.C. § 1001(a) (Congress noting, in ERISA, that employee benefits plans "have become an important factor affecting the stability of employment and the successful development of industrial relations"); *accord* Garner, *Health Insurance Answer Book*, Q 1:15, at 1-7. In fact, a primary reason the federal government -- the nation's largest employer -- established a health benefits program for its own employees was in order to assist "in the recruitment and retention of competent civilian personnel." H.R. Rep. No. 86-957, at 2 (1959). "Enlightened, progressive private enterprise almost universally ha[d] been establishing and operating contributory health benefits programs for its employees," and the federal government had previously made "scant progress" on this issue for its own employees, thereby harming its "competitive position" for the best talent. *Id.* Further, in addition to seeking to increase retention of talented workers, employers provide health coverage for employees to assist with productivity and to reduce absenteeism. *See id.* at 1-2.

In light of these purposes in establishing an ERISA plan in the first place, to then assume that an employer will deny for financial reasons in individual circumstances the benefits it has guaranteed in its plan makes the plan's creation a

futile act. In order to retain its employees, as well as to ensure their well-being and thus productivity, the employer has the exact opposite incentive: to pay the benefits to which the employee is entitled under the plan.

Indeed, if an employer did not want to pay claims, the employer could simply choose not to offer health or other welfare benefits plans. ERISA is a voluntary benefits system; employers are not required to provide benefits to their employees and are allowed to set up plans as they see fit. *See Hughes Aircraft Co. v Jacobson,* 525 U.S. 432, 444 (1999). The employer would not need to go through the charade of creating a plan that it would then administer so as to deny owed benefits, if its overriding intention was to save money. Instead, it could either decline to establish a plan in the first place or create one that was more limited in nature.

For a self-funded plan, as with an insured plan, a denied claim does not directly add to the employer's bottom line, and each paid claim does not subtract from the bottom line. Employers retain the amount of risk they can afford to bear and typically purchase insurance to protect themselves from additional loss. *See* John A. Appleman, *Appleman on Insurance 2d* § 102.7 (2d ed. 2000). For a small employer, this usually results in purchasing a fully-insured plan. A larger employer will probably have enough plan participants to spread the risk and will choose primarily to self-fund the plan and purchase a measure of insurance for protection in the case of catastrophic claims. That catastrophic protection is typically obtained through a "stop-loss" or reinsurance contract. *See* Garner, *Health Insurance Answer Book,* Q 17:52, at 17-21; Appleman,

Appleman on Insurance 2d § 102.3. There are generally two kinds of stop-loss coverage: specific and aggregate. Specific stop-loss will reimburse the employer if an individual participant's claims exceed a set dollar amount during the year, such as $1 million. Alternatively, aggregate stop-loss will reimburse the employer if total claims exceed an aggregate dollar amount in a given year, such as $10 million. Garner, *Health Insurance Answer Book*, Q 17:53, at 17-21.

Because of risk-spreading and stop-loss, even if a claim is significant, the employer with a self-funded plan is not likely to be harmed financially by paying a single claim. Either the affect of the claim will be diluted because the risk is spread across the plan participants or, if the claim exceeds what the employer was financially able to bear, the cost would likely be paid by stop-loss coverage. On this basis, a paid claim cannot simplistically be said to result in a company with a self-funded plan making less money that year.

And just as with insured plans, the employer may suffer greater financial hardship from denying a meritorious claim than paying the claim. No less than a reputation for tightfistedness harms an insurer's customer retention, an employer with a reputation for denying worthy claims will have difficulty retaining its employees; "employers have benefit plans to please employees." *Wright*, 402 F.3d at 74. The employer would also risk its own productivity by denying claims for needed medical services and thereby potentially contributing to absenteeism or the ill-health of the employee.

All of this serves to illustrate that it is simplistic to assume an insurer or employer operates under a

conflict of interest when it both determines and pays claims. A claim denied does not, given the realities and complexities of insurance and self-funded coverage and market features, equal a dollar earned.

C. The Courts Have Not Found Conflicts of Interest in the Context of Non-ERISA Benefits Programs, Where a Decision-Maker Similarly Might Be Perceived to Be Financially Harmed by the Payment of Benefits

There are numerous federal benefits programs in which the government both makes claims decisions and has some responsibility for benefits payments. Yet, the courts have not suggested that a conflict of interest exists; nor have they otherwise subjected government benefits determinations to special scrutiny. The same approach should govern where an ERISA plan administrator both adjudicates and pays benefits.

1. *Federal Employee Health Benefits.* A rough analogy to ERISA among federal programs is the health benefits program established by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914. To that end, courts have sometimes "refer[red] to ERISA and FEHBA cases interchangeably." *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 394 (9th Cir. 2002); *see id.* (comparing FEHBA and ERISA preemption provisions).

Blue Cross and Blue Shield Plans administer, in conjunction with the Blue Cross and Blue Shield Association, and underwrite the largest FEHBA plan -- the "Government-wide service benefit plan." 5 U.S.C. § 8903(1); *see generally Empire HealthChoice*

Assurance, Inc. v. McVeigh, 126 S. Ct. 2121, 2127-28 (2006) (subrogation dispute involving Service Benefit Plan). While this, and other, FEHBA plans are insured products, *see Christiansen v. National Savings & Trust Co.*, 683 F.2d 520, 530 (D.C. Cir. 1982), the government can gain financially to the extent FEHBA-plan benefits are denied, and it can cost the government money when FEHBA benefits are paid. For example, many FEHBA plans are experience-rated, which means the government's costs in succeeding years increase as more claims are paid. *See* 5 U.S.C. § 8902(i). Many also have a feature that premium funds are held in the Treasury and disbursed on a "checks presented" basis (*i.e.*, as claims are incurred), leaving any remainder in reserves for use in subsequent years. *See* 48 C.F.R. § 1632.170(b)(2); *see generally Christiansen*, 683 F.2d at 529-31; *In re Bolden*, 848 F.2d 201, 203 (D.C. Cir. 1988). And Congress directed the federal agency overseeing the FEHBA program to be cognizant of financial costs to the government and to contain them aggressively. *See Doe v. Devine*, 703 F.2d 1319, 1329 (D.C. Cir. 1983) (FEHBA's "entire legislative scheme is based upon [the U.S. Office of Personnel Management] considering cost to the government in contracting for health benefit plans.") (internal quotation marks omitted).

While the government may stand to benefit financially from a particular result on a benefits claim under FEHBA, it also has final adjudicative authority in claims disputes. Under an administrative regime mandated in the FEHBA statute (5 U.S.C. § 8902(j)), and then implemented in federal regulations, the U.S. Office of Personnel Management ("OPM") makes final decisions on

disputed claims, subject then to judicial review. *See* 5 C.F.R. §§ 890.105, .107; *see also Empire*, 126 S. Ct. at 2129 (describing administrative procedure for disputed FEHBA claims).

In actions for judicial review of OPM's final decisions, the courts apply a deferential standard of review, without any qualification due to any purported conflict of interest that would result from the government's role as funder and final adjudicator for a particular FEHBA plan. *See, e.g., Muratore v. United States Office of Personnel Mgmt.*, 222 F.3d 918, 922-23 (11th Cir. 2000) (a court "will defer to OPM's interpretation as long as that interpretation is reasonable and relies on ample factual and legal support"); *accord Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 80 (4th Cir. 1993). By analogy, irrespective of whether an ERISA plan administrator -- not so differently than the government under FEHBA -- funds and adjudicates benefits, courts should not diminish the deference otherwise accorded the claims determination,

Moreover, the FEHBA decisions set forth reasoning for according deference that equally applies in ERISA situations. OPM's decisions enjoy deference, since "OPM does have relevant expertise in this area because it negotiates the contracts at issue and, pursuant to the FEHBA, routinely interprets plans to determine an insurance carrier's liability." *Muratore*, 222 F.3d at 923. ERISA plan administrators that both sponsor the plan and determine claims controversies likewise have knowledge pertaining to the negotiation (or creation) of the plan and have gained expertise on and understanding of plan terms through repeated

adjudications. That is so *only* because the plan administrator has the dual role of funding and determining claims. Absent the duties of sponsorship (including creation and funding of the plan), the plan administrator would be less expert on what the plan was intended to cover; and absent the obligation to determine claims, it could not bring its expertise to bear in final claims decisions. As in the FEHBA context, the dual role *supports* a deferential review, rather than results in a suspect conflict of interest.

2. *Social Security and Medicare Benefits*. Under both the federal Social Security and Medicare programs, the government bears responsibility for paying benefits and adjudicating claims. Deference nonetheless has been afforded to the government's claims determinations, without any qualification for a conflict of interest.

Under both the Social Security Act, 42 U.S.C. §§ 401 *et seq.*, and Medicare, 42 U.S.C. §§ 426, 1395 *et seq.*, benefits are paid from trust funds controlled and, for some benefits, subsidized by the federal government. *See* Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 2007 Annual Social Security and Medicare Trust Fund Reports* (available at http://www.ssa.gov/OACT/TRSUM/trsummary.html) (last visited Mar. 2, 2008). Of course, it is well-known that both programs face serious long-term financial difficulties that will require government "remedial action." *Id.* At the same time, the federal government, through the federal agencies responsible for administering Social Security and Medicare, makes final decisions on disputed claims under the programs, followed by

judicial review. *See* 42 U.S.C. § 405; 20 C.F.R. § 404.900.

Congress has provided that the relevant federal agencies' claims determinations for Social Security or Medicare benefits shall be "conclusive," unless devoid of "substantial evidence." 42 U.S.C. § 405(g). In applying that standard, the courts have held, without any concern for a conflict of interest, that the agencies' final determinations are reviewed under "a deferential standard," such that, "[l]ooking at the administrative record as a whole, we may overturn the Secretary's decision only 'if it is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, or contrary to law.'" *Chipman v. Shalala*, 90 F.3d 421, 422 (10th Cir. 1996) (quoting *Hennepin County Med. Ctr. v. Shalala*, 81 F.3d 743, 748 (8th Cir. 1996)) (Medicare); *accord Lax v. Astrue*, 489 F.3d 1080, 1084 (10th Cir. 2007) (Social Security).

This Court has gone a step further, finding that Social Security examiners do not act as advocates for the government simply because of their ties to it. In *Richardson v. Perales*, 402 U.S. 389, 410 (1971), the Court rejected an "implication of impropriety" with respect to the final decision of a hearing examiner considering a claim for Social Security disability benefits. The claimant complained that the "hearing examiner has the responsibility for gathering the evidence and to make the Government's case as strong as possible." *Id.* at 408-09 (internal quotation marks omitted). This Court said: "Neither are we persuaded by the advocate-judge-multiple-hat suggestion. It assumes too much and would bring down too many procedures designed, and working well, for a governmental structure of great and

growing complexity." *Id.* at 410. The Court held that the hearing examiner simply "acts as an examiner charged with developing the facts." *Id.*

Just as the courts have straightforwardly applied deference to Social Security and Medicare benefits determinations, without any concern that the decision-makers labor under some assumed conflict of interest, so should the Court find that the hearing examiner's counterparts under ERISA do not operate with conflicts of interest. As Judge Easterbrook has put it, "[w]e have no reason to think that the actual decisionmakers [for the ERISA plan] . . . approached their task any differently than do the decisionmakers at the Social Security Administration, and ordinarily deferential review is the order of the day." *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981 (7th Cir. 1999).[5]

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[5] Another analogy suggested by Judge Easterbrook is to federal judges deciding cases important to the United States, which is a federal judge's employer. *Perlman*, 195 F.3d at 981 ("We have no reason to think that UNUM's benefits staff is any more 'partial' against applicants than are federal judges when deciding income-tax cases."). Consider a judge reviewing a multi-billion dollar tax matter prosecuted by the Internal Revenue Service. Even with the enormity of the federal budget, a significant tax matter can be of consequence to the United States. Yet, no special conflicts-of-interest analysis pertains where a judge's determination may have substantial consequence for the United States. Indeed, there was a time when this Court -- rather than looking suspiciously at a judicial determination in a large tax case -- was willing to do the exact opposite and accord special deference to the decisions of the United States Tax Court, due to its

II. EVEN ASSUMING A CONFLICT OF INTEREST DUE TO THE DUAL ROLE, SUCH A CONFLICT NEED NOT BE TAKEN INTO ACCOUNT ON JUDICIAL REVIEW OF A DISCRETIONARY BENEFITS DETERMINATION THROUGH ANY SPECIAL CONSTRUCT

Even in the event the Court deems a conflict to exist because an ERISA plan administrator bears responsibility both for paying and determining claims, the Court need not burden the judicial review process with any special construct to address it. First, ERISA and regulations implemented pursuant to it already fully protect against a plan administrator acting upon any perceived conflict. Second, the abuse-of-discretion standard, without any closer than typical scrutiny, would already require the invalidation of a decision in which a conflict of interest tainted the result. Third, application of a heightened standard would overly complicate ERISA cases, and the minimal nature of the conflict (if one is deemed at all to exist) would not -- on balance -- warrant the complications.

A. ERISA Already Includes Necessary Safeguards to Prevent An Administrator from Acting on a Potential Conflict of Interest

There is no need separately to address the purported conflict of interest on judicial review of discretionary benefits determinations, because ERISA includes multiple safeguards to ensure that

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expertise on tax matters. *See Dobson v. Comm'r*, 320 U.S. 489 (1943).

plan administrators will not act upon any potential conflict.

For instance, ERISA requires a plan fiduciary to ensure, before entering into a contract with a service provider, that the contract or arrangement is reasonable, the services are necessary for the establishment or operation of the plan, and no more than reasonable compensation is paid for the services; an arrangement that does not meet these requirements will not qualify for relief from ERISA's prohibited transaction rules. *See* 29 U.S.C. § 1106(a)(1)(C) (generally prohibiting the furnishing of goods, services, or facilities between a plan and a party in interest to the plan); *id.* § 1002(14)(B) (because a person providing services to a plan is considered a party in interest, the relationship between the service provider and the plan would constitute a prohibited transaction); *id.* § 1108(b)(2) (providing relief from the prohibited transaction rules for service contracts or arrangements between a plan and a party in interest that meet enumerated criteria).

Proposed Department of Labor ("DOL") regulations clarify that, in order for an arrangement to be considered reasonable, service providers must, among other things, disclose any conflicts of interest that may arise in connection with its services to the plan and the procedures that the service provider will implement in order to mitigate the conflicts. *See* 71 Fed. Reg. 70988, 71004-05 (Dec. 13, 2007) (proposed 29 C.F.R. §§ 2550.408b-2(c)(1), -2(c)(1)(C)-(F)). The fiduciary entering the transaction likewise has an obligation to weigh that information before entering the transaction. *Id.* These requirements are designed to create "an opportunity for service

providers to educate plan fiduciaries about how they address potential conflicts of interest." *Id.* at 70992.

Together, then, the current and proposed rules require -- at least where an ERISA plan purchases insurance -- close examination of the service provider's claims procedures and its processes for ensuring against the operation of any conflicts of interest. That examination must occur at the very inception of the insurance relationship.

Additionally, ERISA mandates that a fiduciary "discharge his duties with respect to the plan solely in the interest of the participants and beneficiaries" and "for the exclusive purpose of . . . providing benefits to their participants and their beneficiaries . . . and . . . in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1). These obligations are enforceable through ERISA's remedies for breaches of fiduciary duty under 29 U.S.C. § 1132(a)(2)-(3). In that regard, ERISA authorizes the Secretary of Labor, or a participant, beneficiary, or fiduciary, to bring a civil action for equitable relief and, in certain cases, removal of the fiduciary, where a breach of fiduciary duty has occurred. *See id.* §§ 1109(a), 1132(a)(2). These enforcement tools already act as a powerful bulwark against a claims adjudicator deciding cases with an eye toward financial considerations rather than the participants' interests and the plan's terms.

The DOL has adopted detailed regulations aimed specifically at the claims procedures adopted by ERISA plans. The regulations require every employee benefits plan to establish and maintain reasonable claims procedures that must include, among other things, "administrative processes and safeguards designed to ensure and to verify that . . .

plan provisions have been applied consistently with respect to similarly situated claimants." 29 C.F.R. § 2560-503-1(b)(5). ERISA and the DOL's claims regulations require the administrator to provide claimants a full and fair review (*i.e.*, right to appeal) denied claims. *See* 29 U.S.C. § 1133(1); 29 C.F.R. § 2560.503-1(h)(2). The regulations still further require that a full and fair review in an appeal means an independent review, which does not afford deference to the initial determination, by a named fiduciary who is neither the individual who made the initial benefit determination nor the subordinate of such individual. *See* 29 C.F.R. § 2560.503-1(h)(3)(ii), -1(h)(4). Again, these regulations mitigate the prospect that any perceived conflict of interest arising from an ERISA plan administrator's dual role as adjudicator and payer of claims somehow will affect a claims decision on its merits.

The DOL regulations also require, if the initial determination is based on a medical judgment, that the fiduciary consult with an independent health care professional who was not consulted in connection with the initial determination and is not the subordinate of any such individual. 29 C.F.R. § 2560.503-1(h)(3)(iii), (v), and -1(h)(4). In addition, state laws often reinforce, at least with respect to certain types of health benefits plans, that an independent medical review must occur on claims involving medical judgment. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 375 (2002) (finding that state law requiring health maintenance organization to seek and adhere to decision of outside medical reviewer was saved from preemption under ERISA's insurance saving clause, 29 U.S.C. § 1144(b)(2)(A)). If the Court were to insist on

heightened scrutiny because of a plan administrator's dual role, and if an independent reviewer has already confirmed the claims decision, a court would be closely scrutinizing a decision based on perceived conflicts that the independent reviewer's determination already confirms have not infected the decision.

B. The Abuse-of-Discretion Standard, Without Any Heightening, Would Necessitate Setting Aside Any Decisions Affected by a Conflict of Interest

In any case in which the perceived conflict of interest engendered by a plan administrator's dual role actually manifests itself in a claims decision, the abuse-of-discretion standard already would necessitate setting aside the decision. In *Abatie v Alta Health & Life Insurance Co*, 458 F.3d 955 (9th Cir. 2006), the Ninth Circuit noted that a conflict of interest would evidence itself in ways such as the administrator "provid[ing] inconsistent reasons for [the benefit] denial"; "fail[ing] adequately to investigate a claim or ask the plaintiff for necessary evidence"; "fail[ing] to credit a claimant's reliable evidence"; or "repeatedly deny[ing] benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of the evidence in the record." *Id.* at 968-969. The Solicitor General, at the Petition stage, added that a conflict might manifest itself in an "administrator den[ying] the claimant full and fair review of his claim, as guaranteed by statute and by the Department of Labor's claims regulations." Br. for the U.S. as *Amicus Curiae* Supporting Pet. for Cert. at 16.

But the abuse-of-discretion standard, without any heightening, would already capture each of these infirmities. Abuse-of-discretion review "is not a rubber stamp." *Herman v. Cent. States, S.E. & S.W. Pension Fund*, 423 F.3d 684, 693 (7th Cir. 2005). "The [plan] committee must articulate a rational connection between the facts found, the issue to be decided, and the choice made. Where the committee's interpretation of the plan defies all common sense, the district court must overturn that decision." *Dabertin v. HCR Manor Care, Inc.*, 373 F.3d 822, 828 (7th Cir. 2004) (citation omitted). There is plenty of room already in the abuse-of-discretion standard for setting aside any determination that allegedly contains inconsistent reasoning, is based on inadequate investigation, rejects reliable evidence, rests on supposedly indefensible interpretations of plan terms, is counter to the weight of the evidence, is -- under the DOL's rules -- procedurally defective, or in any other manner might be said to reflect decision-making tainted by a conflict of interest. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833-34 (2003) ("[p]lan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician").

C. Application of a Heightened Standard Would Overly Complicate ERISA Cases

The Court should reject a heightened abuse-of-discretion standard to counter the assumed conflict of interest because determining when and to what extent to apply it would unnecessarily complicate judicial review of ERISA claims decisions. While Congress sought with ERISA "to offer employees

enhanced protection for their benefits," it did not seek to do so through "a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

In any system in which the heightened standard of review would govern, a court would face the threshold issue of determining whether the underlying plan actually was structured in a manner that created the perceived conflict of interest. In other words, would the plan administrator actually face a financial obligation in the event it determined benefits were owed? To answer that question, the court would need to consider whether, if the plan were insured, it was the type of insurance arrangement under which the insurer (if it made the claims decision) bore all of the underwriting risk for claims payments. If, for instance, the insurance contract were retrospectively rated, a decision to pay the claim might threaten no negative financial consequence to the insurer. Or was the insurer so large that the claim could not realistically be said to be a financial tug on the insurer? Was the plan self-funded, with reinsurance to soften the underwriting risk of the plan administrator? Was the plan funded entirely with employee contributions (rather than the sponsor's funds), so that the plan administrator's decision did not so overtly affect its own monies?

None of these questions would be answered from the administrative record created at the plan level, on which the court's review would be based. Instead, the reviewing court would need to convene a factual inquiry at the very start of each ERISA case to determine the type of plan at issue and the extent of

the perceived conflicts of interest. That inquiry alone could involve more resources and time than the review of the merits of the claims decision. When one considers that, at least in the health benefits context, there are millions of ERISA claims determinations annually (involving from the most minimal of consultations to expensive, cutting-edge procedures), and that ERISA cases already constitute a not insignificant portion of the federal courts' docket, the added work created by the new conflicts-of-interest analysis could overwhelm the federal courts.[6]

Once the reviewing court determined that a conflict of interest was potentially present, the court would then have to undertake the heightened review. The approach adopted by the Eleventh Circuit especially shows just how burdensome application of a heightened standard of review can be. Under its approach, a reviewing court first determines, *de novo*, whether or not the denial of benefits was "wrong." *Brown v. Blue Cross & Blue*

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[6] BCBSA itself, acting through a Committee, adjudicates ERISA long-term disability claims funded through an I.R.C. § 501(c)(9) trust for a majority of the Blue Cross and Blue Shield Plans. BCBSA's decision-making procedures under this program have been found to be free of conflicts. *E.g.*, *Ball v. Blue Cross & Blue Shield of Michigan*, No. 4:06-cv-2, 2007 U.S. Dist. LEXIS 4666, *18 n.3 (W.D. Mich. Jan. 23, 2007). Because of the distinction between such trust-funded benefits and the disability program at issue in this case, BCBSA believes any ruling aimed broadly at disability program adjudications should distinguish between programs of the type involved in this case and those that are trust funded as is the case with the program with respect to which the BCBSA Committee exercises claims adjudication duties.

Shield of Ala., Inc., 898 F.2d 1556, 1566 (11th Cir. 1990). If the denial was correct, the reviewing court affirms the administrator's decision; if it was wrong, the "burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Id.* If the administrator meets that burden, the reviewing court then reviews the decision a second time to determine whether, despite being wrong under *de novo* review, the decision might survive under a deferential abuse-of-discretion standard. *See, e.g., HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-95 (11th Cir. 2001).

If this Court were to adopt a regime close to the Eleventh Circuit's approach, a reviewing court -- even if the most minimal of claims were involved -- might have to conduct *de novo* review *and* abuse-of-discretion review, and it would do so only after first completing the substantial task of determining in the first instance whether the plan's structure meant the claims decision-makers conceivably were operating under a conflict of interest. It is questionable whether that exhausting process is warranted even when a serious conflict of interest is at issue; but it more so unnecessary when -- as here -- the conflict is more imagined than real, is safeguarded through other ERISA provisions, and could otherwise be policed through application of a standard abuse-of-discretion inquiry.

CONCLUSION

The judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

– v. –

WANDA GLENN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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STATEMENT OF INTEREST

The *amici* are a group of law professors who collectively teach and write about ERISA, trust law, and this Court's decision making. We have closely followed this Court's interpretations of ERISA and believe its view that trust rather than contract law governs claims for benefits due under an ERISA plan seriously strays from both the text and purpose of the statute, as well as from Congress's intent to apply trust law selectively in ERISA. We also believe that federal courts have fundamentally misapplied the law of trusts to ERISA benefit claims with the perverse outcome of *lessening* rather than *increasing* protections for ERISA plan participants, contrary to Congress's intentions.[1]

SUMMARY OF ARGUMENT

1. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court made a foundational assumption that donative trust law

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[1] Petitioner has filed a letter giving blanket consent to the filing of *amicus* briefs in this case. Additionally, Respondent has consented to the filing of this brief. We have provided each party with notice of our intent to file this *amicus* brief more than 10 days prior to this filing. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation of this brief. No person other than the *amici* and their employer, the University of Oklahoma College of Law, made a monetary contribution to its preparation or submission.

provides the paradigm for evaluating a worker's legal entitlement to contractual benefits under an ERISA plan. That assumption is incorrect and should be repudiated, rather than perpetuated, in this case. While trust law may control certain actions under ERISA, see, e.g., *LaRue v. DeWolff, Boberg & Associates*, 522 U.S. __ (2008) (breach of fiduciary duty under 29 U.S.C. § 1132(a)(2)), contract law should govern claims for benefits due under 29 U.S.C. § 1132(a)(1)(B).

First, the separate and distinct causes of action in ERISA's civil enforcement provision—including a claim "to recover benefits due" under a plan, 29 U.S.C. § 1132(a)(1)(B), a claim for breach of fiduciary duty, 29 U.S.C. § 1132(a)(2), and a claim for "other appropriate equitable relief," 29 U.S.C. § 1132(a)(3)—demonstrate that Congress carefully devised different remedies for the different kinds of injuries that may arise in the administration of an ERISA plan.[2]

Second, the injury arising from the erroneous denial of a benefit due under the terms of an ERISA plan has contractual rather than fiduciary origins. This case demonstrates the difference

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[2] A selected legislative history of ERISA, beginning January 1, 1973, is complied in a three volume committee print. See 1-3 Subcomm. on Labor of the Senate Comm. on Labor and Pub. Welfare, 94th Cong., Legislate History of the Employee Retirement Income Security Act of 1974 (Comm. Print 1974) (hereafter, Leg. Hist.).

dramatically. Unlike *LaRue*, there is no claim under § 1132(a)(2) for breach of fiduciary duty due to improper "management, administration, and investment" of plan assets, 522 U.S. at __ (Slip Op. at 5). Nor is there any claim for "other appropriate equitable relief" arising from a breach of trust or breach of other fiduciary responsibilities. In this action, there are no plan assets and there is no trust—only a group disability insurance policy purchased by the employer from Petitioner MetLife to pay promised benefits. Moreover, even where an ERISA plan sponsor chooses to fund plan promises through the establishment of a trust, the trust serves not as the *source* of the parties' legal rights and obligation, but merely as a *security device* to help guarantee that the plan sponsor will fulfill the obligations in its bargained-for employee benefit plan. In short, in cases involving unfunded plans or insured plans, as well as in cases involving funds held in trust, an unvarnished claim "to recover benefits due . . . under the terms of [an ERISA] plan," 29 U.S.C. § 1132(a)(1)(B), is nothing more or less than a legal claim of contractual right.

Third, the key exceptions to ERISA's preemption of state law establish that Congress intended state insurance law, not trust law, to govern benefit claims arising under insured welfare benefit plans. The insurance savings clause, 29 U.S.C. § 1142(b)(2)(A), suggests that claims against an insured ERISA plan will be resolved in the same fashion as any state insurance dispute—that is, under state insurance contract law. See *UNUM v. Ward*, 526 U.S. 358 (1999). ERISA's second savings

provision, 29 U.S.C. § 1144(d), which provides that ERISA does not supersede any other federal law, including the delegation of insurance regulation to the states under the McCarran-Ferguson Act, 15 U.S.C. § 1012, reinforces that conclusion.

Accordingly, as a prelude to applying *Firestone*, this Court should disavow the uncritical assumption in that case that donative trust law principles control straightforward claims for benefits due under an ERISA plan. Instead, this Court should apply contract law to such claims, as recommended by the Solicitor General of the United States in *Firestone*. See Brief of the United States as *Amicus Curiae* Supporting Respondents, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)(87-1054), *available on* LEXIS at 1987 U.S. Briefs 1054 (United States *Firestone Amicus* Brief).

2. Even if Congress had intended the law of trusts to govern claims for benefits due under an ERISA plan, federal courts following *Firestone's dicta* have misapplied basic trust law by treating the ERISA plan administrator as an adjudicator rather than a mere fiduciary subject to plenary court review. Moreover, federal courts have ignored the trust law no-further-inquiry rule. That rule imposes an irrebuttable presumption against a self-dealing fiduciary that a conflict of interest caused biased decision making, and as a result mandates *de novo* review of benefit denials by dual-role plan administrators.

First, as a general matter, proceedings in state court for breach of trust or breach of fiduciary duty are plenary in nature. By contrast, federal district courts typically utilize a summary process to resolve ERISA benefit disputes that discards standard procedural and adjudicative tools designed to assure fair deliberation. These courts routinely prohibit ERISA plan participants from conducting discovery or from presenting or cross-examining witnesses to explore the merits of a benefit denial. Instead, as this case demonstrates, district courts usually conduct a summary review proceeding based entirely upon the mis-labeled "administrative record," which essentially consists of nothing more than the claims adjuster's investigatory file.

Given the lack of opportunity for adversarial development of the record—compounded by the absence of formal adjudication by a neutral decision maker—reliance by district courts on administrative law analogies to deny plan participants basic discovery and trial rights enjoyed by almost every other civil litigant in federal court, and certainly afforded every claimant under a state law-governed group disability insurance policy, finds no warrant in this Court's due process jurisprudence, its ERISA decisions, or the common law of trusts. See *Concrete Pipe and Products of California, Inc. v. Construction Laborers Pension Trust for Southern California*, 508 U.S. 602 (1993). Further, such summary proceedings fly in the face of clear congressional intent in establishing an original, plenary action in federal court to protect

plan contract benefits, see 29 U.S.C. § 1001(b), after twice rejecting specific proposals to include an administrative adjudicatory process to resolve benefit claims.

Second, lower courts that fail to recognize that dual-role plan administrators operate under an inherent conflict of interest misapply foundational principles of trust law by confusing the existence of a conflict with the need to prove causation. Under the common law of trusts, a beneficiary challenging the decisions of a self-dealing fiduciary does not have to prove causation. Rather, once a beneficiary establishes a fiduciary's conflict of interest, the common law no-further-inquiry rule presumes that the conflict improperly motivated the fiduciary's decision. In the context of self-dealing ERISA plan insurers, the no-further-inquiry rule dictates that trial courts disregard the initial claims decision of the conflicted plan administrator and examine the claims dispute *de novo*. See Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 OKLA. L. REV. 637, 672-684 (2005); cf. United States *Firestone Amicus* Brief, at *17 ("There is no good reason to defer to an employer's construction of the terms of an employee benefit plan when it is paying benefits out of its own pocket."). Indeed, it would be the height of irony to misapply trust law principles in the ERISA context to accord beneficiaries *less* protection, instead of *more* protection, than they enjoyed prior to ERISA, given Congress's declared policy in enacting the statute "to protect . . . the

interests of participants in employee benefits plans and their beneficiaries." 29 U.S.C. § 1002(b).

ARGUMENT

I. CONGRESS INTENDED CONTRACT RATHER THAN TRUST LAW TO GOVERN WORKER CLAIMS TO RECOVER BENEFITS DUE UNDER A PLAN CONTRACT PURSUANT TO 29 U.S.C. § 1132(a)(1)(B).

A. Firestone *has produced confusion and perverse outcomes.*

1. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that an employee's claim for benefits due under an ERISA welfare benefit plan, filed pursuant to 29 U.S.C. § 1132(a)(1)(B), should be evaluated *de novo* by the trial court. *Id.* at 115. The Court's holding essentially endorsed the same fair and reasonable processes historically applied in state court breach of contract actions. See *id.* at 112. Crucial to the Court's holding was the understanding that Congress intended ERISA to help safeguard plan participant rights that, for various reasons, had not been adequately protected when some courts applied trust law to resolve benefit disputes prior to ERISA. See S. REP. NO. 93-127, at 28-30 (1973), *reprinted in* 1 Leg. Hist. 614-16; H.R. REP. NO. 93-

533, at 11-12 (1973), *reprinted in* 2 Leg Hist. 2358-60.[3] The *Firestone* Court notably remarked that:

> Adopting Firestone's reading of ERISA [mandating deferential review of benefit denials] would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.

Firestone, 489 U.S. at 113-114.

The *Firestone* Court agreed with the United States Solicitor General in holding that workers were entitled to a plenary, *de novo* trial. Nevertheless, despite the Court's express rejection of a trust law paradigm as adapted by lower courts from actions implied under § 302 of the Labor Management Relations Act, 29 U.S.C. § 186, the *Firestone* Court failed to adopt the Solicitor General's rationale and conclusion that contract

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[3] See Donald T. Bogan, *ERISA: Rethinking* Firestone *in Light of* Great-West—*Implications for Standard of Review and the Right to a Jury Trial in Welfare Benefit Claims*, 37 J. MARSHALL L. REV. 629, 650-654 and 664-668 (2004) (hereafter, Bogan, *Rethinking* Firestone) (summarizing history of employee benefit plans legal status); Jay Conison, *Foundations of the Law of Plans*, 41 DEPAUL L. REV. 575 (1992) (providing detailed history of legal status of plans and noting that courts originally viewed employee benefits as unenforceable gifts).

law, not trust law, offered the proper legal paradigm to evaluate ERISA benefit claims. See *Firestone*, 489 U.S. at 109-10.[4] Instead, the Court stated that "[i]n determining the . . . standard of review for actions under § 1132(a)(1)(B), we are guided by principles of trust law." *Id.* at 111.

2. Confusion with the trust law paradigm in the lower courts, and the injustice of creating a system where courts defer to the decisions of one party to the contract in a breach of contract dispute, see *Sentinel Acceptance Corp. v. Colgate*, 424 P.2d 380, 382 (Colo. 1967) (contract void where seller was granted sole discretion to interpret terms), counsel that this Court should reject trust law as the paradigm to evaluate ERISA employee benefit claims.

The Solicitor General was correct in 1989 when he urged:

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[4] The LMRA analogy is not entirely off the mark; however, lower courts compared the wrong LMRA remedy to ERISA claims for benefits due under a plan. LMRA § 301, 29 U.S.C. § 185, provides an express breach of contract remedy that is analogous to ERISA's claim for benefits due under 29 U.S.C. § 1132(a)(1)(B). See H.R. CONF. REP. 93-1280, at 327 (1974), *reprinted in* 3 Leg. Hist. 4594. LMRA § 301 claims are resolved under contract law standards, not trust law. See *Chauffeurs, Teamsters & Helpers Local No. 391 v. Terry*, 494 U.S. 558 (1990). See also Bogan, *Rethinking* Firestone, *supra* n. 3, at 656-60.

> [T]he objectives of the statute are best served by resolving questions of plan interpretation under established principles of contract interpretation, rather than by affirming decisions of the employer-administrator unless arbitrary and capricious. That approach comports with two of ERISA's primary objectives—insulating benefit decisions from the self-interest of employers and ensuring that employees who qualify for benefits actually receive them.
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> Trust analogies are plainly inapposite here . . . since Firestone established no separate body of trust assets to pay severance benefits, and the common law of trusts does not support application of the arbitrary and capricious standard to administrators' decisions in that instance. ERISA's own reliance on trust principles is selective and in no way suggests Congress intended that a highly deferential standard be applied here. . . . Furthermore, review under the arbitrary and capricious standard in cases involving unfunded plans administered by employers would be ironic in that employees

> would be worse off than they were before ERISA was enacted.

United States *Firestone Amicus* Brief, at *16-17.

The *Firestone* Court's statement that trust law governs ERISA benefit claims, inexplicably following the Court's rejection of the LMRA trust law analysis, has produced a result exactly opposite of what the Court expressly tried to avoid, and contrary to Congress's intentions in enacting ERISA. Due to the application of deferential review, nominally applied under trust law in the lower courts, workers are now presented with significantly greater burdens in their efforts to enforce their rights to promised welfare benefits, including disability insurance benefits, than they were prior to ERISA.

B. Congress intended contract law principles to govern actions under 29 U.S.C. § 1132(a)(1)(B).

1. Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans . . . *and to protect contractually defined benefits.*" *Firestone*, 489 U.S. at 112 (internal citations omitted) (emphasis added). As this Court is aware, Congress established a comprehensive civil enforcement scheme in ERISA offering plan participants and their beneficiaries a variety of remedies, including a remedy "to recover benefits due . . . under the terms of [a] plan," 29 U.S.C § 1132(a)(1)(B), a

separate remedy for breach of fiduciary duty, 29 U.S.C § 1132(a)(2), and a separate right to recover "other appropriate equitable relief." 29 U.S.C § 1132(a)(3).

An action to recover benefits due under a plan states a claim to recover money damages for breach of contract. While trust law may inform the ERISA remedy for breach of fiduciary duty under 29 U.S.C § 1132(a)(2), trust law has no connection with ERISA's separate remedy to recover benefits due under a plan contract. The law abounds with circumstances where claimants may select from alternative remedies governed by different legal paradigms.

For example, doctors serve as fiduciaries to their patients. *See* Leslie J. Miller, *Informed Consent: I*, 244 JAMA 2100, 2100 (1980) ("[I]nformed consent doctrine is an outgrowth of the Anglo-American concept of the fiduciary relationship."). If a disgruntled patient decides to sue her doctor, she may assert a negligence claim, or a breach of contract claim, or a breach of fiduciary duty claim. If the patient chooses to pursue a breach of contract claim against the doctor, courts do not apply trust law to the action and courts do not defer to the doctor's decision-making, simply because the doctor owed a fiduciary duty to the patient. See *Dingle v. Belin*, 749 A.2d 157, 164 (Md. 2000) ("Most [suits against doctors] are tort-based . . . and occasionally, in misrepresentation or fraud; some are contract-based. When they are pursued either alternatively

or in combination, care must be taken to keep the actions separate and not to allow the theories, elements, and recoverable damages to become improperly intertwined.").[5]

2. This Court's precedents largely support the view that 29 U.S.C. § 1132(a)(1)(B) creates a contractual remedy. With one exception, every time this Court has explored ERISA's civil enforcement scheme to characterize the nature of the statute's various express remedies, this Court has suggested that a claim for benefits due under a plan pursuant to 29 U.S.C. § 1132(a)(1)(B) seeks legal damages for breach of the plan contract. In the sole instance where the Court characterized that claim as one for breach of fiduciary duty, Justice Thomas, joined by Justices O'Connor and Scalia, discredited that *dictum* in a persuasive dissenting opinion passage.

In *Massachusetts Mutual Life Insurance Co v. Russell*, 473 U.S. 134 (1985), the plan participant received all of her of contract benefits after some significant haggling with her insurer/plan administrator. She ultimately sued the insurer complaining of bad faith during the claims

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[5] See also *Rash v. J.V. Intermediate, LTD*, 498 F.3d 1201 (10th Cir. 2007) (fiduciary duty and breach of contract claims arising from employment relationship); *Garrett v. Bryan Cave, LLP*, 2000 U.S. App. LEXIS 7339, *11-16 (10th Cir. 2000) (unpublished) (citing Missouri and Oklahoma cases where both negligence and breach of fiduciary duty claims were separately pursued against lawyers).

adjustment process. Since she had received her full contract benefits, the plan participant had no claim under § 1132(a)(1)(B). Consequently, she sued under 29 U.S.C. § 1132(a)(2), seeking extra-contractual damages for the plan administrator's alleged breach of fiduciary duty. In comparing the various remedies contained in § 1132, the *Russell* Court characterized actions under 29 U.S.C. § 1132(a)(1)(B) as claims to recover "contractually authorized benefits." *Russell*, 473 U.S. at 147. See *Mertens v. Hewitt Associates*, 508 U.S 248, 256-58 (1993) (29 U.S.C. § 1132(a)(3), which authorizes a claim for equitable relief, does not allow a claim for money damages, the classic form of legal relief).

In 2002, this Court examined the interrelation of ERISA's civil enforcement scheme in the context of an insurer's claim to enforce its contractual right to subrogation or reimbursement under the terms of the plan. In *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), the insurer had paid medical bills for a plan participant, but then wanted to recoup those payments when the plan beneficiary obtained a third-party tort recovery. Because the ERISA provision authorizing recovery of contractual benefits, 29 U.S.C. § 1132(a)(1)(B), runs only to a plan participant or beneficiary, Great-West could not sue under ERISA to enforce its contract rights. Consequently, Great-West tried to craft its pleading as a claim for equitable relief under 29 U.S.C. § 1132(a)(3).

This Court held that despite Great-West's characterization of the claim as one for equitable restitution, it was really just seeking money damages, which were not available under § 1132(a)(3). See *Great-West*, 534 U.S. at 210. Notably, while evaluating the nature of Great West's § 1132(a)(3) claim, the Court contrasted that claim for equitable relief with ERISA's express remedy under § 1132(a)(1)(B) allowing a plan participant "to enforce his rights under the plan." *Great-West*, 534 U.S. at 220-21. See *LaRue v. DeWolff, Boberg and Assocs., Inc.*, 552 U.S. __ (2008) (Roberts, C.J., concurring) (Slip Op. at 3) (suggesting that the plan participant's characterization of her claim as one for equitable relief may have been a ruse to avoid the limitations of ERISA's breach of contract remedy under 29 U.S.C. § 1132(a)(1)(B)).

In *Varity Corp v. Howe*, 516 U.S. 489 (1996), workers sued their former employer seeking individual relief under 29 U.S.C. § 1132(a)(3) for breach of fiduciary duty. A Varity plan fiduciary allegedly made misrepresentations that caused workers to release Varity from its obligations under an existing plan in exchange for coverage under a new plan with a new spin-off corporation. Since the workers were no longer participants in the old plan or employees of Varity, they could not pursue their contractual claim for benefits due under 29 U.S.C. § 1132(a)(1)(B). Instead, the workers pursued a breach of fiduciary duty claim seeking individual damages (and not damages on behalf of the plan)

against Varity for "other appropriate equitable relief" under 29 U.S.C. § 1132(a)(3).

Varity argued that ERISA only allows a claim for breach of fiduciary duty under 29 U.S.C. § 1132(a)(2), and that to construe the "other appropriate equitable relief" language of 29 U.S.C. § 1132(a)(3) as allowing individual damages for breach of fiduciary duty would be redundant. Rejecting Varity's redundancy argument, the *Varity* majority remarked that § 1132(a)(1)(B) also provides a remedy for breach of fiduciary duty. See *id.* at 512 (citing *Firestone*). Justice Thomas directly challenged that remark. He stated:

> The majority apparently believes that . . . 29 U.S.C. § 1132(a)(1)(B) "provides a remedy for breaches of fiduciary duty with respect to the interpretation of plan documents and the payment of claims." *Ante* at 512 (citing *Russell*, 473 U.S., at 144). Since, in the majority's view, § [1132](a)(1)(B) allows for individual recovery for fiduciary breach outside the framework created by §§ [1109] and [1132](a)(2), the majority wonders "[w]hy should we not conclude that Congress provided yet other remedies for yet other breaches of other sorts of fiduciary obligation in another, 'catchall' remedial section?" *Ante*, 516 U.S. at 512.

> The answer is simple. Contrary to the majority's misunderstanding, § [1132](a)(1)(B) does *not* create a cause of action for fiduciary breach, and *Russell* expressly rejected the claim that it does. . . . Section [1132](a)(1)(B) deals exclusively with contractual rights under the plan.

See *id.* at 521 n.2 (Thomas, J., dissenting) (emphasis in original).

3. ERISA's express preemption language reveals that Congress did not intend trust law to govern a claim for benefits due under an insured welfare benefit plan. The insurance savings clause in 29 U.S.C. § 1144(b)(2)(A) indicates that Congress intended employee benefit claims arising under insured plans to be resolved under state insurance contract law. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379-380, 385-86 (2002) (state insurance law that creates right to appeal health insurance claim denial to independent reviewer does not provide alternate remedy in conflict with ERISA's civil enforcement scheme and is saved from ERISA preemption, even though the state law provides the rule of decision to govern the outcome of an ERISA benefits claim dispute); *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999) (state notice/prejudice rule, saved from preemption as a law that regulates insurance, provides the rule of decision to resolve ERISA benefit claim under insured welfare benefit plan).

More specifically, under an insurance contract issued in the state of Ohio (as in most states), an insurer owes its insured a duty of good faith and fair dealing. See *Zoppo v. Homestead Insurance Co.*, 644 N.E.2d 397 (Ohio 1994). Within that duty is the obligation to interpret ambiguous policy terms in favor of the insured.[6] Additionally, the insurer typically owes the insured a duty not to construe all contested evidence in its own favor in order to deny coverage. See *Gruenberg v. Aetna Insurance Co.*, 510 P.2d 1032 (Cal. 1973). These duties supplement the underlying insurance contract obligations owed by the insurer, and they are not preempted by ERISA.

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[6] The insurance law duty of good faith and fair dealing here is different than the doctrine of *contra proferentum*. Under *contra proferentum*, a court interprets ambiguous contract terms against the drafter. The duty of good faith and fair dealing applies to the insurer, not the court, and prevents the insurer from advocating for itself in the claims evaluation process. See STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES § 5A:07 (2nd ed.1997) (referencing the contract law reasonable expectations doctrine to differentiate between *contra proferentum* and the insurance law duty of good faith and fair dealing). The insurance law duty arises from the insurer's separate promise to its insureds that by purchasing insurance, the insured is also buying a certain level of security that the insurer will be there for the insured when an emergency arises that causes the insured to make a claim under the insurance contract. See *Beck v. Farmers Insurance Exchange*, 701 P.2d 795, 802 (Utah 1985); *Crisci v. Security Insurance Co.*, 426 P.2d 173, 179 (Cal. 1967).

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court ruled in the context of an insurance bad faith claim that ERISA's civil enforcement provision impliedly preempts all state law remedies arising from the denial of benefits under an ERISA plan. Implied preemption in such circumstances, however, only voids the insured's state law bad faith *remedy*; it does not supersede the insurer's state law *duty* to act in good faith. ERISA's express savings clause exception to preemption for state laws that regulate insurance preserves the insurer's duty of good faith and fair dealing, which can provide the rule of decision that will control a claim for benefits due under an ERISA plan. See Donald T. Bogan, *ERISA: State Regulation of Insured Plans after* Davila, 38 J. MARSHALL L. REV. 693 (2005).

Consequently, in actions like this one for benefits due under a fully insured disability benefits plan, ERISA contemplates that the full panoply of state insurance contract law would continue to govern insurers engaged in the claims adjustment process. See also 29 U.S.C. § 1144(d) (saving McCarran-Ferguson Act, 29 U.S.C. § 1012, which delegates the regulation of insurance to the states, from ERISA preemption).

C. Donative trust law is inapplicable when a trust is utilized merely as a security device to help guarantee performance of contractual obligations.

1. ERISA requires sponsors of pension plans to fund such plans through the establishment of a trust or through the purchase of insurance annuity contracts, 29 U.S.C. § 1103(a). However, the statute's funding rules do not apply to welfare benefit plans. See 29 U.S.C. § 1081(a)(1). Consequently, plan sponsors may choose to fund welfare benefit plans through the establishment of a trust, or through the purchase of insurance, or plan sponsors may pay promised benefits out of operating capital. See Bogan, *Rethinking* Firestone, *supra* n.3, at 670-72. When plan sponsors use a trust to fund plan obligations, the trust merely serves as a security device to help guarantee that the employer's contractual promises to pay specified benefits will be performed.

The ERISA trust, when utilized, serves a similar function as the deed of trust in a secured real estate transaction, where a promissory note is backed by an interest in the real estate subject of the purchase. As in the real estate deed of trust, the ERISA trust does not form the basis of the parties' legal obligations and benefits; rather, it is the underlying contract—the promissory note in the real estate deal and the plan contract in the ERISA context—that contains the operative legal promises that define the parties' obligations and benefits.

2. The authors of the RESTATEMENT OF TRUSTS have recognized that principles of donative trust law do not necessarily apply to commercial

trusts or to trusts used as a security device. They write:

> The law relating to the use of trusts as devices for conducting business and investment activities outside the express private- and charitable-trust context is not within the scope of this Restatement . . . . The law relating to the use of a trust as a security device or as an arrangement for the benefit of creditors also is not within the scope of this Restatement.

See RESTATEMENT (THIRD) OF TRUSTS § 1, *comment b* (2003)[7]

3. Congress also doubted whether donative trust law could provide a proper paradigm to evaluate claims arising under an insured welfare benefit plan. Senate Report No. 93-127 on ERISA recites:

> First, a number of plans are structured in such a way that it is unclear whether the traditional law

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[7] Additionally, the Restatement includes new language (added since *Firestone*) that addresses the applicability of the Restatement to federal law governing pension plans, indicating that donative trust law does not necessarily apply to the "fundamentally different considerations" applicable to such plans. See RESTATEMENT (THIRD) OF TRUSTS § 1, *comment a* (2003).

> of trusts is applicable. Predominantly, these are plans, such as insured plans, which do not use the trust form as their mode of funding.

S. REP. NO. 93-127, at 28-30 (1973), *reprinted in* 1 Leg. Hist. 614-16.

Further, Congress recognized the incongruity of applying trust law to an ERISA plan that utilizes a trust as a funding device to secure contractual benefits in the context of a commercial transaction, rather than to accomplish a gift among family members:

> [E]ven where the funding mechanism of the plan is in the form of a trust, reliance on conventional trust law often is insufficient to adequately protect the interests of plan participants and beneficiaries. This is because trust law had developed in the context of testamentary and inter vivos trusts (usually designed to pass designated property to an individual or small group of persons) with an attendant emphasis on carrying out the instructions of the settlor. Thus if the settlor includes in the trust document an exculpatory clause under which the trustee is relieved

> from liability for certain actions which would otherwise constitute a breach of duty, or if the settlor specifies that the trustee shall be allowed to make investments which might otherwise be considered imprudent, the trust law in many states will be interpreted to allow the deviation. In the absence of a fiduciary responsibility section . . . courts applying trust law to employee benefit plans have allowed the same kind of deviations, even though the typical employee benefit plan, covering hundreds or even thousands of participants, is quite different from the testamentary trust both in purpose and in nature.
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> It is expected that courts will interpret [ERISA's] fiduciary standards bearing in mind the special nature and purposes of employee benefit plans . . .

S. REP. NO. 93-127, at 28-30 (1973), *reprinted in* 1 Leg. Hist. 614-16.

Thus, ERISA's legislative history establishes that Congress intended fiduciary

principles to supplement contractual obligations where needed to secure protections for plan beneficiaries, rather than to indiscriminately apply a body of law based upon motivations of gratuitous transfers of property to all ERISA plans and causes of action. Indeed, with respect to unfunded or insured welfare benefit plans, like the one at issue, Congress contemplated straightforward contractual rather than donative law principles to govern benefit disputes:

> [The fiduciary responsibility section] when read in connection with the definition of the term "employee benefit fund" makes it clear that the fiduciary provisions apply only to those funds which leave assets at risk. While [ERISA] has the effect of requiring all retirement plans subject of that Act to be financed through the medium of a segregated fund, there may be welfare funds . . . such as those providing sickness or disability benefits, which may not be funded. Thus an unfunded plan in which the only assets from which benefits are paid are the general assets of the employer is not covered.

S. REP. NO. 93-127, at 28-30 (1973), *reprinted in* 1 Leg. Hist. 614-16.[8]

D. Applying donative trust law to this case makes no trust law sense.

When a settlor uses a trust to make a gift to several family members, a trustee may need to make decisions about the distribution of trust assets that affect all beneficiaries. Where a finite trust *res* provides the only funding source for the trust, a distribution to one beneficiary necessarily limits the assets available to distribute to the other deserving beneficiaries. Due to the limited source of funds under such a donative trust, the trustee often must balance the interests of one beneficiary against the interests of preserving the *res* for the remaining beneficiaries. These considerations,

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[8] See John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA*, 101 NW. L. REV. 1315, 1317 (2007) ("There is . . . a profound difference of purpose between ordinary trust law and ERISA fiduciary law. Because the normal private trust is essentially a gift, trust law exhibits great deference to the wishes of the transferor. In ERISA, by contrast, Congress imposed trust law concepts for regulatory purposes, to restrict rather than to promote the autonomy of the employer over its employee benefit plans. This fundamental difference of purpose should lead the Court to restrict the power of an ERISA plan sponsor to alter the standard of judicial review.").

which form the foundation for court deference under donative trust law, have no relation to a contract of insurance. See United States *Firestone Amicus* Brief at *28.

This case, of course, is even further removed from donative trust law than the circumstance of a deed of trust or a commercial trust because Sears did not fund the subject disability benefits plan through a trust. Instead, Sears purchased a group disability insurance policy from the MetLife to implement the promise to its workers to pay disability benefits. The application of donative trust law principles to govern the relationship between insured plan participants and the payor/insurer MetLife under a group disability insurance policy is simply not analogous to the relationship and motivations of a settlor intent on making a gift to family members that is the foundation for the law of trusts.

Rather, in this action, every plan participant or beneficiary who meets the disability criteria of the insurance contract is legally entitled to full benefits, without concern for the rights or claims of other plan participants. See *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1050-1051 (7th Cir. 1987) (Posner, J.) ("In the case of defined-benefit pension plans . . . the company has contractual obligations that it must honor whether or not the pension trust is adequately funded."). In the defined benefit disability insurance plan at issue here, there is no legitimate reason for MetLife to balance one plan participant's rights against any

other plan participant's rights. Further, there is no legal basis for the plan administrator, or the Court, to balance the contract rights of existing and deserving plan participants against the employers' interest in keeping future insurance premiums low.

II. EVEN IF CONGRESS INTENDED TRUST LAW TO GOVERN ERISA BENEFIT CLAIMS, FEDERAL COURTS HAVE MISAPPLIED BASIC TRUST LAW BY (1) TREATING THE ERISA PLAN ADMINISTRATOR AS AN ADJUDICATOR RATHER THAN A MERE FIDUCIARY SUBJECT TO PLENARY COURT REVIEW, AND (2) BY IGNORING THE TRUST LAW NO-FURTHER-INQUIRY RULE, WHICH MANDATES *DE NOVO* REVIEW OF BENEFIT DENIALS BY DUAL-ROLE PLAN ADMINISTRATORS.

A. Lower courts have misapplied trust law by treating the ERISA plan administrator as an adjudicator rather than a mere fiduciary subject to plenary court review.

1. In *dicta* that has proven to define the opinion, the *Firestone* Court suggested that under trust law, the payors of employee benefit claims could obtain deferential review of claim denials by inserting magic language into the plan contract granting broad discretionary powers to the plan administrator. See *Firestone*, 489 U.S. at 111, 115. Unsurprisingly, following *Firestone* most plan sponsors have inserted an express grant of

"discretionary" authority empowering the plan administrator to determine eligibility for benefits and to construe plan terms.[9] Relying on the *Firestone dicta*, lower courts now routinely defer to plan administrator decisions to deny worker benefit claims under an abuse of discretion standard of review.[10]

2. Abuse of discretion deference in ERISA has imposed significantly greater obstacles on ERISA plan participants than the application of deference in traditional trust law actions. In trust

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[9] It is questionable whether these self-serving contractual awards of "discretion" grant anything. The act of construing contract terms is a judicial function, not a discretionary act. Additionally, finding facts from conflicting evidence in order to determine a plan participant's eligibility for benefits under the plan contract is an act of adjudication, not a discretionary decision. Nevertheless, lower courts have followed the *Firestone dicta* and allowed ERISA plan sponsors to contract away the duty of loyalty ERISA expressly imposes on fiduciaries who exercise discretion. This *dicta* is particularly unfortunate because ERISA expressly prohibits plan sponsors from including exculpatory clauses in an ERISA plan that purport to relieve a fiduciary from its exclusive duty of loyalty. 29 U.S.C. § 1110. See United States *Firestone Amicus* Brief, at *27.

[10] Most circuits have found that the "abuse of discretion" review standard and the "arbitrary and capricious" review standard are the same and use the language interchangeably. But see *Booth v. Wal-Mart Stores, Inc.*, 201 F.3d 335 (4th Cir. 2000) (arbitrary and capricious standard of review is more deferential than the abuse of discretion standard, and applying abuse of discretion standard).

cases, courts conduct plenary trials, even while applying deference to a trustee's discretionary decisions in appropriate cases.[11] In ERISA benefit cases, however, lower federal courts typically deny workers the right to conduct discovery or to present live witness testimony in their civil actions to recover promised benefits. See *Liston v. UNUM Corp. Officer Severance Plan*, 330 F.3d 19, 23-24 (1st Cir. 2003) (citing cases). Instead, as was the case here, deferential review of ERISA claims usually entails summary review of a "record" limited to whatever (unsworn) materials the plan administrator relied upon to the deny the claim. See Joint Appendix; *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981-82 (7th Cir. 1999) ("There should not have been any inquiry into the thought processes of UNUM's staff."); *Perry v. Simplicity Engineering*, 900 F.2d 963, 966-67 (6th Cir. 1990) (even where review is *de novo* under *Firestone* because the plan did not grant discretionary powers to the administrator, review is based upon the record before the plan administrator—no new evidence may be received in court to support the plan participant's claim for benefits).

3. When federal courts employ the summary "record review" process, they confuse adjudicative

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[11] See, e.g., *Noriega v. Pearce*, 2007 WL 4295798 (Cal 2007) (unpublished) (citing California cases); *Hubbell v. Houston*, 441 P.2d 1010, 1012 (Okla. 1967) (breach of fiduciary duty).

deference common under administrative law, see Frank H. Easterbrook, *Judicial Discretion in Statutory Interpretation*, 57 OKLA. L. REV. 1, 4-5 (2004), with fiduciary deference under trust law. See *Herzberger v. Standard Insurance Co.*, 205 F.3d 327, 332 (7th Cir. 2000) (Posner, J.). See also *Perlman*, 195 F.3d at 983-30 (Wood, J., dissenting); Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727 (2004). The summary record review process common in ERISA cases mistakes the underlying insurance claims adjustment process for a formal "adjudication" of the dispute.

This Court's decision in *Concrete Pipe and Products of California, Inc. v. Construction Laborers Pension Trust for Southern California*, 508 U.S. 602 (1993), dramatically underscores the difference in an analogous ERISA context. In *Concrete Pipe*, an employer seeking to withdraw from a multiemployer ERISA plan appealed from an adverse liability assessment by the plan trustees. Under the Multiemployer Pension Plan Amendments Act of 1980 (MPPAA), 29 U.S.C. §§ 1381-1461, plan trustees issue a liability assessment to withdrawing employers in order to reconcile what would have been the employer's anticipated future contributions to the plan for vested pension plan participants. While an employer can appeal the trustees' withdrawal assessment to binding arbitration, see 29 U.S.C. § 1401(a)(1), the MPPAA requires the arbitrator in such an appeal to presume that the trustees'

assessment is correct. See 29 U.S.C. § 1401(a)(3)(A). Concrete Pipe argued that the plan trustees were conflicted in making their withdrawal liability assessment because the trustees owed a fiduciary duty to increase the assets of the plan for the benefit of the remaining plan participants, and that an adjudication of the assessment by such biased trustees, therefore, violated due process standards. See *Concrete Pipe*, 508 U.S. at 615-18.

The *Concrete Pipe* Court held that the arbitrator provides the initial adjudication under the MPPAA, not the trustees. The trustees did not have to provide due process protections to the withdrawing employer, according to the Court, because the trustees were merely a party to the dispute, like a prosecutor presenting charges. See *id.* at 618-19. As such, the trustees could advocate for their position in aggressively assessing withdrawal liability under the statute.

Notably, the *Concrete Pipe* Court also held that the statutory presumptions in favor of trustees' decisions, 29 U.S.C. § 1401, which are analogous to the deference lower courts give to the discretionary decisions of ERISA plan administrators in § 1132(a)(1)(B) benefit actions, were unconstitutional. See *Concrete Pipe*, 508 U.S. at 626-30. In order to satisfy adjudicative due process standards, this Court ruled that MPPAA arbitrator/adjudicators must disregard the statutory presumption in favor of plan trustees in making withdrawal liability assessments. Rather,

the arbitrator must consider each party's position without any presumptions in a plenary, *de novo* adjudication. See *id.*

Similarly in this case, this Court should find that Congress did not intend ERISA plan administrators to serve as "adjudicators," and that trial courts, therefore, must conduct plenary, *de novo* trials for ERISA benefit claims. A contrary conclusion would present thorny constitutional issues. If Congress had intended to relegate adjudication of employee benefit claims to ERISA plan administrators, the Court would have to evaluate whether such relegation of a private contract dispute violates Article III of the Constitution. Plan administrators, of course, are not salary-protected, life-tenured federal judges.[12] Additionally, viewing private plan administrators, appointed by one contracting party without input from the other party to the dispute, as "adjudicators," and then deferring to such conflicted adjudicators on appeal, would raise serious constitutional concerns.[13]

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[12] See *Northern Pipeline Constr. Co. v. Marathon Pipe Line Co.*, 458 U.S. 50, 58 (1982) (plurality opinion). See generally, Martin H. Redish, *Legislative Courts, Administrative Agencies, and the* Northern Pipeline *Decision*, 1983 DUKE L. J. 197.

[13] See Mark D. DeBofsky, *What Process is Due in the Adjudication of ERISA Claims*, 40 J. MARSHALL L. REV. 811 (2004). See also Henry Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267, 1279-95 (1975) (administrative hearing must provide an unbiased

(footnote continued...)

4. ERISA's legislative history confirms that Congress intended to create an original, plenary proceeding in 29 U.S.C. § 1132(2)(1)(B), governed by the rules of civil procedure and contract law principles.

ERISA recites that Congress enacted the consumer protection law "to protect . . . the interests of participants in employee benefit plans . . . by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). This vital aspect of ERISA withstood several attempts to weaken plan participants' rights to enforce plan promises in a plenary federal court civil action.

The Senate Finance Committee recommended that administrative adjudicatory authority be granted to the Department of Labor under ERISA. See S. 1179, 93d Cong. § 602, at 209-11 (1973), *reprinted in* 1 Leg. Hist. 780, 988-90; S. REP. NO. 93-383 at 116-17 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4890, 4999-5000,

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adjudicator, notice, opportunity to challenge the proposed action, right to cross-examine adverse witnesses, right to review evidence, right to evidentiary record, right to counsel, articulated reasons for any decision, right to public hearing, and right to judicial review.).

and *reprinted in* 1 Leg. Hist. 1184-85.[14] After the Senate initially rejected this Finance Committee proposal, a later attempt to reinsert the administrative adjudication provision was also defeated. See 120 CONG. REC. 29,563 (1973), *reprinted in* 1 Leg. Hist. 1245-47; 119 CONG. REC. 30,401 (1973), *reprinted in* 2 Leg. Hist. 1835-38. The delegation of adjudicatory authority did not appear in the final Senate Bill submitted to Congress, and of course, does not appear in ERISA. Congress also rejected a proposal to allow arbitration of employee benefit claims, in favor of establishing the right to pursue an employee benefit claim in federal district court as an original, plenary civil action. See H.R. 2, 93d Cong. § 691, at 566-67 (1974), *reprinted in* 3 Leg. Hist. 3813-14; 120 CONG. REC. 29,941 (1974) (remarks of Sen. Javits), *reprinted in* 3 Leg. Hist. 4769.

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[14] A number of lower courts have cited *Perry v. Simplicity Engineering*, 900 F.2d 963 (6th Cir. 1990) to support application of the summary record review process in ERISA claims, referencing the *Perry* Court's suggestion that Congress intended to create a quick and inexpensive claims process in ERISA. See, e.g., *Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 815-16 (7th Cir. 2006); *Recupero v. New Eng. Tel. & Tel. Co.*, 118 F.3d 820, 831 (1st Cir. 1997). The *Perry* citation to support that conclusion, however, is misplaced. *Perry* cited the legislative history of this effort to impose an administrative dispute resolution process for employee benefit claims, see *Perry*, 900 F.2d at 967, which, of course, Congress ultimately rejected.

5. In *Firestone*, this Court remarked that Congress left a "gap" in the statute by failing to "set out the appropriate standard of review for actions under § 1132(a)(1)(B)." *Firestone*, 489 U.S. at 109. Rather than Congress leaving a gap in the statute, however, the failure of ERISA to include a designated standard of review demonstrates that Congress intended claims under 29 U.S.C. § 1132(a)(1)(B) to proceed as original, plenary actions in federal district court. This is a classic case of the dog that did not bark.[15]

The phrase "standard of review" is generally a term of appellate procedure, and is typically incorporated at the district court level when the district court sits as a quasi-appellate tribunal—for example in an appeal from the ruling of an administrative law judge under the Administrative Procedure Act.[16] That phrase ordinarily does not come into play at the district court level. The

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[15] See Arthur Conan Doyle, *Silver Blaze*, in THE COMPLETE WORKS OF SHERLOCK HOLMES 383, 400 (1938).

[16] In administrative law, a neutral Administrative Law Judge (ALJ) adjudicates a dispute delegated by the legislature to the administrative law process. The Administrative Procedure Act or some enabling legislation typically authorizes the right to appeal from an administrative adjudication. See, e.g., 5 U.S.C. § 702 (right to judicial review), and see 5 U.S.C. § 706(2)(A) (establishing deferential standard); see also 5 U.S.C. § 556(e) (record consists of transcript of testimony and exhibits together with all papers and requests filed in the proceeding).

Federal Rules of Civil Procedure contemplate a plenary, original trial process as the default rule.

While this Court has approved the use of a summary proceeding outside the ambit of the rules of civil procedure in certain very limited circumstances, the Court has only authorized such summary process where Congress has clearly and expressly established its intention to create such an abbreviated proceeding.

> Summary trial of controversies over property . . . rights is the exception in our method of administering justice. . . . [T]he Federal Rules of Civil Procedure provide the normal course for beginning, conducting, and determining controversies. Rule 1 directs that the Civil Rules shall govern all suits of a civil nature . . . Rule 2 directs that "There shall be one form of action to be known as a 'civil action.'" . . . Rule 56 sets forth an expeditious motion procedure for summary judgment *in an ordinary, plenary civil action*. . . . The very purpose of summary rather than plenary trial is to escape some or most [] trial procedures. . . . [S]ummary trials . . . were practically unknown to the English common law and . . . they have little acceptance in this country. In the absence of express statutory

> authorization, courts have been extremely reluctant to allow proceedings more summary than the full court trial at common law.

New Hampshire Fire Insurance Co. v. Scanlon, 362 U.S. 404, 406-407 (1960) (emphasis added).

Given that Congress did not indicate any intention in ERISA that courts should resolve ERISA benefit claims in a summary appellate fashion, Congress had *no reason* to contemplate in 1974 that this Court would expect some explicit instruction in ERISA directing trial courts to conduct plenary, *de novo* trials in actions for benefits due filed pursuant to 29 U.S.C. § 1132(a)(1)(B).

B. The trust law no-further-inquiry rule prohibits courts from deferring to the decisions of self-dealing fiduciaries

1. Courts misconstrue foundational principles of trust law when they fail to recognize an inherent conflict of interest where the ERISA plan administrator responsible for determining a worker's eligibility for benefits under a plan also serves as the plan insurer. Trust law does not merely recognize that conflict in such circumstances is a possibility; it appreciates the certainty of conflict in the plan administrator who suffers from self-interested financial incentives antagonistic to the interests of the beneficiaries. See UNIF. TRUST CODE § 802

cmt., 7C U.L.A. 590 (2006) ("[Transactions affected by a self-dealing conflict of interest] are irrebuttably presumed to be affected by [the conflict]. It is immaterial whether the trustee acts in good faith or pays a fair consideration."); RESTATEMENT (THIRD) OF TRUSTS § 170 (2003).[17]

Circuit court opinions that suggest dual-role ERISA fiduciaries do not suffer a conflict of interest confuse the existence of a conflict with the need to prove causation. Compare *Mers v. Marriot Internat'l Group Accid. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir.), *cert. denied*, 525 U.S. 947 (1998), with *Perlman*, 195 F.3d at 983-85 (Wood, J., dissenting). Under the trust law no-further-inquiry rule, a beneficiary challenging the decisions of a conflicted fiduciary does not have to prove causation.[18] Once the beneficiary establishes the

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[17] See also GEORGE G. BOGERT, ET AL., THE LAW OF TRUSTS AND TRUSTEES § 543 (rev. 2d ed. 1993) ("[I]t is generally, if not always, humanly impossible for the same person to act fairly in two capacities and on behalf of two interests in the same transaction.").

[18] See *Wendt v. Fischer*, 154 N.E. 303, 304 (N.Y. 1926) (Cardozo, J.) ("[W]e are told that the [conflicted fiduciary] acted in good faith . . . This is no sufficient answer by a trustee forgetful of his duty. The law does not stop to inquire whether the contract or transaction was fair or unfair. It stops the inquiry when the relationship is disclosed, and sets aside the transaction . . . without undertaking to deal with the question of abstract justice in the particular case. Only by this uncompromising rigidity has the rule of undivided loyalty

(footnote continued...)

fiduciary's conflict of interest, the law irrebuttably presumes that the conflict improperly motivated the decision. See Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 OKLA. L. REV. 637, 672-684 (2005).

2. Any suggestion that Congress intended to displace the trust law no-further-inquiry rule because ERISA allows the plan sponsor to also serve as plan administrator fails to credit

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been maintained against disintegrating erosion.") (internal quotations omitted). See also *In re Ryan's Will*, 52 N.E.2d 909, 923-34 (N.Y. 1943) ("[T]he [no-further-inquiry] rule is founded in the highest wisdom. It recognizes the infirmity of human nature, and interposes a barrier against the operation of selfishness and greed.") (internal quotation marks and citations omitted); *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928) ("Many forms of conduct permissible in the workaday world for those acting at arm's length are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior. As to this there has developed a tradition that is unbending and inveterate. Uncompromising rigidity has been the attitude of courts of equity when petitioned to undermine the rule of undivided loyalty by a disintegrating erosion of particular exceptions. Only thus has the level of conduct for fiduciaries been kept at a level higher than trodden by the crowd.") (internal quotation marks and citation omitted).

Congress's consumer protection goals in enacting the statute, and fails to comprehend Congress's regulatory purpose of overriding historic trust law rules that may otherwise permit settlors more leniency in expressly allowing a trustee under a gift trust to also receive a benefit under the trust. See John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA*, 101 NW. L. REV. 1315, 1317, 1335-1342 (2007). See also S. REP. NO. 93-127, at 28-30 (1973), 1 Leg. Hist. 614-16.

ERISA's express fiduciary provisions—most notably, 29 U.S.C. § 1104(a)(1)(A) (requiring an ERISA fiduciary to exercise its duty of loyalty for the exclusive purpose of providing benefits), and 29 U.S.C. § 1110 (forbidding exculpatory clauses that purport to relieve a fiduciary from its exclusive duty of loyalty)—demonstrate that Congress did not intend to write the most stringent trust law consumer protection, the no-further-inquiry rule, out of the protections afforded plan participants. See *Central States, S.E. & S.W. Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 568 (1985) ("[T]rust documents cannot excuse trustees from their duties under ERISA."); *NLRB v. Amax Coal Co.*, 453 U.S. 322, 333 at n.16 (1981) ("Although § 408 (c)(3) of ERISA permits a trustee of an employee benefit fund to serve as an agent or representative of the union or employer, that provision in no way limits the duty of such a person to follow the law's

fiduciary standards while he is performing his responsibilities as trustee.").

CONCLUSION

If this Court fails to correct the defective processes that have evolved in the lower courts from the application of donative trust law to simple breach of contract claims, ERISA plan participants will continue to suffer the tragic irony that following adoption of the celebrated consumer protection statute, workers are worse off now than they were before ERISA was enacted. See *Firestone*, 489 U.S. at 113-114. This Court should re-invigorate its *Firestone* holding that courts must conduct plenary, *de novo* trials for ERISA benefit claims under 29 U.S.C. § 1132(a)(1)(B). Additionally, as urged by the United States Solicitor General in *Firestone*, this Court should now embrace a contract law framework for evaluating such benefit claims.

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METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

– v. –

WANDA GLENN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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STATEMENT OF INTEREST[1]

The Legal Aid Society - Employment Law Center ("LAS-ELC") is a non-profit public interest law firm whose mission is to protect, preserve, and advance the workplace rights of individuals from traditionally under-represented communities. Since 1970, the LAS-ELC has represented plaintiffs in cases involving the rights of employees in the workplace, particularly those cases of special import to communities of color, women, recent immigrants, individuals with disabilities, and the working poor. Employee benefits are crucial to low-wage workers because they do not have financial resources of their own to obtain medical benefits or pay living expenses in the event of disability.

The LAS-ELC has appeared before this Court on numerous occasions both as counsel for plaintiffs, *see National Railroad Passenger Corp. v. Morgan*, 536 U.S. 101 (2002); *U.S. Airways, Inc. v. Barnett*, 535 U.S. 391 (2002); and *California Federal Savings & Loan Ass'n v. Guerra*, 479 U.S. 272 (1987) (counsel for real party in interest), as well as

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[1]Pursuant to Supreme Court Rule 37.6, amicus states that no person or entity other than the amicus curiae, and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. Written consent to the filing of this brief has been obtained from the parties in accordance with Supreme Court Rule 37.3(a). Copies of the consent letters have been filed with the Clerk.

in an amicus curiae capacity, *see, e.g., U.S. v. Virginia*, 518 U.S. 515 (1996); *Harris v. Forklift Systems, Inc.*, 510 U.S. 17 (1993); *International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991); *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987); *Meritor Savings Bank v. Vinson*, 477 U.S. 57 (1986). The LAS-ELC has a strong interest in protecting the employee benefit rights of its clients.

SUMMARY OF ARGUMENT

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), this Court determined that where the plan document gives the administrator discretionary authority to determine eligibility for benefits and interpret the plan, but the administrator has a conflict of interest, that conflict "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115, *quoting* Restatement (Second) of Trusts § 187, cmt. d (1959) (alteration in original).

The first question presented by this case, "Whether an administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C.1001 *et seq.*, is operating under a conflict of interest that must be weighed on judicial review of a benefit determination," has been answered in the affirmative by a substantial majority of circuits. *See, e.g., Post v. Hartford Ins. Co.*, 501 F.3d 154, 162 (3d Cir. 2007) ("We have

long held that a structural conflict arises when the administrator has a non-trivial financial incentive to act against the interests of the beneficiaries.")

Only two circuits, the First and the Seventh, have determined that a financial conflict of interest is no conflict at all. *See Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), *cert. denied*, 525 U.S. 947 (1998); *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005). [2] The approach of these two circuits stands in opposition to the Supreme Court's previous statements on this subject and should be rejected. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n. 15 (2002) ("In *Firestone Tire* itself, we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised."); *see also Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965 n.5 (9th Cir. 2006) (en banc) (noting that although the *Firestone* Court "did not catalogue the full range of types of conflicts of interest, . . . it suggested that a conflict exists when a plan administrator (which acts as a fiduciary toward the plan participants, who are beneficiaries) is also the sole source of funding for an unfunded

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[2] *Cf. Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (acknowledging the presence of the financial conflict of interest, although not weighing the conflict unless the participant proves it tainted the decision).

plan; this was Firestone's situation"). Further, the Solicitor General agrees that a financial conflict of interest is an inherent conflict of interest and that this "type of conflict generally warrants careful scrutiny in the trust context, even in the absence of evidence that the plan administrator actually acted because of its financial self-interest." Solicitor's Cert. Br. at 13-14.

The second question presented – "If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?" – is one that has befuddled the lower courts. As noted by the Third Circuit, "Since *Firestone*, courts have struggled to give effect to this delphic statement, and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir. 2000). While many circuits have employed some variation on the "sliding scale" approach, which reduces the deference afforded to the conflicted administrator's decision as the "weight" of the conflict of interest increases, this approach is much-criticized – even by the circuits employing it – as not providing sufficient guidance to the lower courts to enable judicial consistency. As the Seventh Circuit has noted, the fundamental unanswered question in the sliding scale approach is: "How *much* does [a conflict of interest] weigh? [One court] recently

concluded that it can't weigh very much without exceeding the judicial capacity to tailor standards of review. Judges understand deferential and non-deferential review, but intermediate variations blur into one another without promoting understanding or consistent adjudication." *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999).

Lower courts, plan participants, and plan administrators will all benefit from clear direction from this Court on how to weigh a dual-role administrator's conflict of interest. Just as in *Firestone*, the Court should again look to trust law to adopt the standard suggested by Respondent: when a "beneficiary serves as a trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." Restatement (Third) of Trusts § 37, cmt. f(1). Additionally, where other factors besides the inherent financial conflict of interest are present that demonstrate biased decision-making by the administrator, such as a history of denying meritorious claims, reliance on the reports of biased medical reviewers, violations of the Department of Labor's regulations in the claims review process, or inconsistent reasons for denying a claim, the Court should hold that the decision is entitled to very little deference, if any.

ARGUMENT

I. INTRODUCTION

Most circuits have held that a financial conflict of interest is a conflict that must be weighed in determining whether there has been an abuse of discretion, in accordance with *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Because two circuits have clearly rejected this analysis, the Court should clarify that a financial conflict of interest, where the administrator both makes the claims decision and pays for the benefits, is indeed a conflict of interest and must be taken into account.

Once the Court confirms that threshold conflict of interest, the Court should provide concrete guidance to the lower courts to enable them to weigh that conflict pursuant to *Firestone*. Specifically, the Court should hold that when a "beneficiary serves as a trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." Restatement (Third) of Trusts § 37, cmt. f(1). The Court should provide further guidance by outlining several additional factors that automatically alter the standard of review, such that if any of those factors are present, the conflicted administrator's decision receives little, if any, deference

II. *FIRESTONE* MANDATES THAT COURTS "MUST" WEIGH A CONFLICT OF INTEREST AS A FACTOR IN EXAMINING THE CLAIM FIDUCIARY'S DECISION.

Citing trust law principles, this Court in *Firestone* held that the default standard of review of benefits decisions under ERISA plans is de novo except where a plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or interpret the terms of the plan. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the plan grants such discretionary authority to the plan administrator or fiduciary, then the district court will review a claim denial under the "abuse of discretion" standard. *Id.*

In the ERISA context, the courts have adopted different formulations of the abuse of discretion standard of review, which is sometimes referred to as the "arbitrary and capricious" standard.[3] The Seventh Circuit has gone so far as to describe this standard as similar to a "loud guffaw" test:

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[3] Many courts have mistakenly treated "arbitrary and capricious" and "abuse of discretion" review as the same. *See, e.g., Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1471 (9th Cir. 1993) ("abuse of discretion" standard and "arbitrary and capricious" standard the same). *See generally* Petitioner's Br. § II A.

> Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review of administrative action. Any questions of judgment are left to the agency, or here to the administrator of the Plan.

Pokratz v. Jones Dairy Farm, 771 F.2d 206, 209 (7th Cir. 1985), *overruled on other grounds by Firestone*, 489 U.S. at 115. *See also Rud v. Liberty Life Assu Co. of Boston*, 438 F.3d 772, 773 (7th Cir. 2006) (insurer's decision "was not so off the wall that it could be adjudged 'arbitrary and capricious.'") *But see Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994) (cautioning that courts must not act as "a rubber stamp" under abuse of discretion standard).

In conducting a de novo review, "the district court considers a denial-of-benefits challenge afresh, without deferring to the [administrator's] interpretation of the plan." *Allen v. Adage, Inc.*, 967 F.2d 695, 697 (1st Cir. 1992). *See also Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990) (de novo review means a review "without deference to the decision or any presumption of correctness").

Most importantly for the present case, the *Firestone* Court also stated that "if a benefit plan gives discretion to an administrator or fiduciary

who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115, *quoting* Restatement (Second) of Trusts § 187, cmt. d (1959) (alteration in original). More recently, this Court has acknowledged the need for courts to scrutinize decisions made by conflicted plan administrators:

> An issue implicated by this case but requiring no resolution is the degree to which a plan provision for unfettered discretion in benefit determinations guarantees truly deferential review. In *Firestone Tire* itself, we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised. That last observation was underscored only two Terms ago in *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 147 L.Ed.2d 164 (2000), when we again noted the potential for conflict when an HMO makes decisions about appropriate treatment, see *id.*, at 219-220, 120 S. Ct. 2143. It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest.

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 384 n. 15 (2002).

Thus, this Court's precedents require that where a conflict of interest exists, courts must take that conflict into account when deciding whether

there has been an abuse of discretion. The lower courts, however, have struggled with the issues of what is a conflict of interest and, once identified, how that conflict is weighed.

III. UNDER *FIRESTONE* AND TRUST LAW, COURTS MUST WEIGH A FINANCIAL CONFLICT OF INTEREST IN REVIEWING A CLAIM DENIAL.

Petitioner presents the question of "[w]hether an administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C.1001 *et seq.*, is operating under a conflict of interest that must be weighed on judicial review of a benefit determination." The answer is yes.

Where, as in this case, an ERISA plan fiduciary both determines eligibility for benefits and pays those benefits, most circuits acknowledge that there is an inherent financial conflict of interest. *See, e.g., Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (acknowledging the presence of the financial conflict of interest, although not weighing the conflict unless the participant proves it tainted the decision); *Post v. Hartford Ins. Co.*, 501 F.3d 154, 162 (3d Cir. 2007) ("We have long held that a structural conflict arises when the administrator has a non-trivial financial incentive to act against the interests of the beneficiaries."); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997); *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 395

(5th Cir. 2006); *Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (6th Cir. 1998) (holding that where the administrator also funds the plan, there exists "an actual, readily apparent conflict," rather than a merely potential conflict because "it incurs a direct expense as a result of the allowance of benefits, and it benefits directly from the denial or discontinuation of benefits"); *Barnhart v. Unum Life Ins. Co. of Am.*, 179 F.3d 583, 588 (8th Cir. 1999); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-66 (9th Cir. 2006) (en banc) ("On the one hand, such an administrator is responsible for administering the plan so that those who deserve benefits receive them. On the other hand, such an administrator has an incentive to pay as little in benefits as possible to plan participants because the less money the insurer pays out, the more money it retains in its own coffers."); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) ("Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business.").

In his brief in support of granting the Petition for Certiorari, the Solicitor General also agrees that a financial conflict of interest is an inherent conflict of interest. Solicitor's Cert. Br. at 13. The Solicitor noted that because every claims decision made by a dual-role administrator affects its bottom line,

"[t]hat type of conflict generally warrants careful scrutiny in the trust context, even in the absence of evidence that the plan administrator actually acted because of its financial self-interest." *Id.* at 13-14. The Department of Labor predicted that ERISA plan fiduciaries and administrators would deny more than 42 million claims in 2002. *See* 65 Fed. Reg. 70246, 70263 (Nov. 21, 2000). For-profit insurance companies cannot avoid taking into consideration the potential liability represented by the aggregate of these denied claims.

The Seventh and First Circuits, however, hold that an insurer acting as a dual-role administrator has only a potential conflict and the insurer is presumed to be neutral. *Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), *cert. denied*, 525 U.S. 947 (1998); *Wright* v. *R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005). In *Mers*, the Seventh Circuit found that no conflict existed because the insurer was a "Fortune 500" company and the financial impact of granting the particular benefit sought in the instant case was minuscule. 144 F.3d at 1020-21. Following the Seventh Circuit's analysis to its logical conclusion means an insurer, which has billions of dollars in assets, would never be deemed to have a financial incentive to deny a claim, because no single disability claim could possibly be large in comparison. This view ignores the reality that the accumulation of claim payments determines any insurer's bottom line. Indeed, the First Circuit has recently expressed reservations about its rejection

of a financial conflict of interest as being a conflict that alters the standard of review, calling its position "increasingly difficult to defend" in light of other circuits' analyses of the issue. *Denmark v. Liberty Life Assur. Co. of Boston*, 481 F.3d 16, 31 (1st Cir. 2007).

Moreover, the Seventh Circuit's approach is also based on the presumption that courts should not rewrite the terms of a contract. *See Rud v. Liberty Life Life Assur. Co. of Boston*, 438 F.3d 772, 775-77 (7th Cir. 2006). The Seventh Circuit's fundamental error is to view ERISA merely as a part of contract law, rather than as a statute based on trust law. *Id.* at 776 (assuming that an insurer would make adverse benefit decision out of financial self-interest "would destabilize large reaches of contract law, of which ERISA is, after all, a part . . . ."). However, this Court has already determined that trust law, not contract law, applies in these cases. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989). *Rud* ignores this precedent, and even suggests that "*Firestone* goes too far" by interfering with contract rights. 438 F.3d at 776.

Viewed from the perspective of trust law, this Court has stated that where the fiduciary has a financial interest in the claims decision, the "fiduciary capacity [is] necessarily compromised." *Pegram v. Herdrich*, 530 U.S. 211, 227 (2000). *See also* Restatement (Third) of Trusts § 37 cmt. f(1) (when trustee has a conflict of interest, "the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny").

The financial conflict of interest is significant because "insurance companies have an active incentive to deny close claims in order to keep costs down and keep themselves competitive." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000); *see also Fought*, 379 F.3d at 1006. The common law of trusts assumes that "[a] conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." *Brown*, 898 F.2d at 1565. As the Third Circuit recently noted,

> The Second Restatement, on which the Supreme Court relied in *Firestone*, defines a "conflict" as merely "an interest in the trustee conflicting with that of the beneficiaries." Restatement (Second) of Trusts § 187 cmt. d (1959). This statement is worded broadly—almost to the point of being tautological—but it applies by its own terms to a situation in which the administrator has an interest (*e.g.*, in profit or a better bottom line) that is adverse to the interests of beneficiaries seeking payment.

Post, 501 F.3d at 162-63. Therefore, an insurance company that decides benefit claims and pays benefits from its own assets has an inherent conflict of interest that warrants especially careful scrutiny by a court reviewing a claim denial.

IV. THE MAJORITY OF CIRCUITS EMPLOY "SLIDING SCALE" TESTS TO WEIGH CONFLICTS OF INTEREST. THE LOWER COURTS NEED FURTHER GUIDANCE ON HOW TO ACCOUNT FOR CONFLICTS OF INTEREST.

The Court also granted certiorari on the following question suggested by the Solicitor General: "If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?" A structural financial conflict of interest should automatically reduce the deference afforded to the conflicted administrator, and the Court should outline several other specific factors, *see* Section V, below, to give concrete guidance on what other types of evidence show that a conflict of interest may have tainted the administrator's decision and how to reduce the deference afforded to the conflicted administrator.

The lower courts are in need of clear guidance on this issue because, while most circuits apply some form of the "sliding scale" test, they have been unable to articulate what that means, and still others apply a standard other than the "sliding scale." After *Firestone*, the lower courts have adopted essentially four different approaches to "weighing" a claim fiduciary's conflict of interest in the review of a benefit claim denial: "sliding scale" (1st, 3rd, 4th, 5th, 6th, 7th, 8th, and 10th Circuits);

the credibility determination with guiding factors (9th Circuit); "smoking gun" (2nd Circuit); and burden shifting (11th Circuit).[4] The standards of the Ninth and Eleventh Circuits best account for a dual-role administrator's conflicts of interest, but, as explained below, still need further clarification to result in consistent adjudication.

A. The Sliding Scale Test.

The sliding scale test

> grants the administrator deference in accordance with the level of conflict. Thus, if the level of conflict is slight, most of the administrator's deference remains intact, and the court applies something similar to traditional arbitrary and capricious review; conversely, if the level of conflict is high, then most of its discretion is stripped away.

Post v. Hartford Ins. Co., 501 F.3d 154, 161 (3d Cir. 2007).

Most circuits that have adopted the sliding scale test have not given the district courts enough

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[4]The D.C. Circuit has not yet adopted an approach after *Firestone*. *See, e.g., Wagener v. SBC Pension Benefit Plan-Non Bargained Program*, 407 F.3d 395, 402 (D.C. Cir. 2005) (acknowledging a circuit split on the issue and declining to adopt a position where the plaintiff would prevail under any standard of review).

guidance as to how to apply the sliding scale metaphor. Indeed, half of the circuits that have adopted the sliding scale have explicitly expressed reservations for this reason. *See Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999) ("How *much* does [a conflict of interest] weigh? [One court] recently concluded that it can't weigh very much without exceeding the judicial capacity to tailor standards of review. Judges understand deferential and non-deferential review, but intermediate variations blur into one another without promoting understanding or consistent adjudication."); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000) (sliding scale is "intellectually unsatisfying, or at least discomforting . . . [for] it is not clear how the process required by the typical arbitrary and capricious review changes."); *Barnhart v. Unum Life Ins. Co.*, 179 F.3d 583, 589 n.9 (8th Cir. 1999) (sliding scale standard "presents a considerable hurdle for plaintiffs. Logically, a plaintiff who can show that a conflict of interest or serious procedural irregularity caused a serious breach of the administrator's fiduciary duty will more than likely have substantial evidence showing that the fiduciary's decision was arbitrary and capricious."); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005) ("To say that there is a sliding scale of deference, however, merely begs the question: *how much* less deference ought a reviewing court afford? Our past opinions do not clearly address this question. . . . Our failure to articulate clearly the requirements of a less deferential arbitrary and

capricious standard has left district courts in this circuit without direction and has encouraged litigation.").

In practice, the sliding scale too often results in untempered deferential review of decisions made by conflicted fiduciaries because courts have no guidance as to what standard of review to apply that is less deferential than abuse of discretion review but not as rigorous as de novo review. *See, e.g., Nolan v. Heald College*, 2007 WL 878946, *12-13 (N.D. Cal. Mar. 12, 2007) (court stated that it properly weighed MetLife's structural conflict of interest without elaborating on how it weighed that conflict, then upheld the administrator's decision); *Schofield v. Metro. Life Ins. Co.*, 2006 WL 3359197, *3 (E.D. Cal. Nov. 20, 2006) (concluding that the court would review the administrator's decision with a "high degree of deference" despite presence of structural conflict of interest, and therefore upholding the administrator's decision); *Matos v. Lorillard Tobacco Co. Group Disability Ins. Plan*, 391 F. Supp. 2d 392, 398 (M.D.N.C. 2005) (stating that "Continental Casualty's dual role of plan administrator and plan insurer indeed creates such a conflict of interest necessitating the application of the sliding scale standard of review," then concluding that there had been no abuse of discretion without analysis of how the sliding scale affected the decision); *Brodish v. Federal Express Corp.*, 384 F. Supp.2d 827, 833 (D. Md. 2005) (explaining that defendant had a "mild" conflict of interest, but holding that there was no abuse of

discretion without explanation about the impact of the conflict).

Moreover, the courts have expressed discomfort at the unfair results when judicial hands are tied by the abuse of discretion standard. In *Brigham v. Sun Life of Canada*, 317 F.3d 72, 82, 86 (1st Cir. 2003), the First Circuit upheld an insurer's denial of disability benefits to a paraplegic under the abuse of discretion standard, but stated:

> [W]e confess considerable ambivalence about whether Brigham *should* be expected to return to the workforce . . . it seems counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled. . . . [but] the undisputed facts of records do not permit us to find that Sun Life acted in an arbitrary or capricious manner in terminating appellant Brigham's benefits.

(emphasis in original).

First Circuit: While the First Circuit avoids using "sliding scale" terminology, it still employs a sliding scale test. It characterizes the lesser deference afforded to plan decisions influenced by a conflict of interest as being arbitrary and capricious review with "more bite." *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (holding that "fine gradations in phrasing are as likely to complicate as to refine the standard," and that the "essential

requirement of reasonableness has substantial bite itself"). In the First Circuit, if there is sufficient "bite," the scale can slide all the way to de novo review. *See Janeiro v. Urological Surgery Prof'l Ass'n*, 457 F.3d 130, 142 (1st Cir 2006) (applying the level of "bite" necessary to account for the severity of the conflict may require "no deference to the conflicted decisionmaker"). In criticizing the "more bite" approach, the Seventh Circuit aptly noted that courts using this standard of review "have never come up with an operational definition of 'more bite' or a specification of the appropriate circumstances for mastication." *Perlman*, 195 F.3d at 981.

Third Circuit: The Third Circuit explained that in its application of the sliding scale approach, the court "approximately calibrat[es] the intensity of our review to the intensity of the conflict." *Pinto*, 214 F.3d at 393. However, at the same time the court also acknowledged that the standard is "intellectually unsatisfying, or at least discomforting. . . . [for] it is not clear how the process required by the typical arbitrary and capricious review changes." *Id.* at 392. Recently, the court acknowledged that "[i]n the face of non-trivial evidence of procedural bias, the standard of review should be raised; the more difficult question is how much." *Post*, 501 F.3d at 165.

Fourth Circuit: The Fourth Circuit in *Elliot v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999), modified the abuse of discretion standard to the extent necessary to counteract any "influence

unduly resulting from the conflict." In *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 233-34 (4th Cir. 1997), the court explained that "[t]he more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it." This explanation, however, only underscores the inevitable subjectivity that results in inconsistent adjudication under the sliding scale approach: the word "more" does not quantify how far down the scale a court should slide.

Fifth Circuit: In *Vega v. National Life Insurance Services*, 188 F.3d 287, 297 (5th Cir. 1999) (en banc), the Fifth Circuit reaffirmed that "[t]he greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be." Again, the terms "greater" and "less" deference provide little guidance to the district courts for consistent adjudication.

Sixth Circuit: As articulated by the Sixth Circuit in the opinion below, district courts must discuss the role of the administrator's conflict of interest and give that conflict "weight," to determine whether the decision is the "result of a principled reasoning process." *Glenn v. MetLife*, 461 F.3d 660, 666, 674 (6th Cir. 2006), *cert. granted*, 128 S. Ct. 1117 (2008). Nonetheless, the court characterizes this weighted review as a

"highly deferential standard." *Id.*; *see also Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1069 (6th Cir. 1998) (concluding that the fiduciary will be entitled to some deference, but that "application of the standard should be shaped by the circumstances of the inherent conflict of interest"). The instruction to "weigh" a conflict to "shape" judicial review while simultaneously applying a highly deferential standard is a contradiction in itself, and is an example of why further guidance is necessary.

Seventh Circuit: As quoted above, in an attempt to apply *Firestone's* instruction to weigh conflicts of interest as a factor in the standard of review, the Seventh Circuit noted the need for clarification on "how much" a conflict of interest should weigh. *Perlman*, 195 F.3d at 986. However, the Seventh Circuit also employs the sliding scale approach, despite questioning its ability to promote "understanding or consistent adjudication." *Id.*; *see also Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815 (7th Cir. 1997) ("The more serious the conflict, the less deferential our review becomes.")

Eighth Circuit: The Eighth Circuit determined in *Clapp v. Citibank N.A. Disability Plan*, 262 F.3d 820, 827 (8th Cir. 2001), that a court should give less deferential sliding-scale review if the claimant produces material probative evidence that a palpable conflict was connected to the administrator's decision so as to cause a serious breach of fiduciary obligation. Like other circuits, the Eighth Circuit acknowledges that there is an

inherent problem with this approach: if the plan participant has produced the required evidence to trigger a sliding scale review, the plan participant also likely would be able to receive a favorable result under the traditional abuse of discretion review. *Barnhart*, 179 F.3d at 589 n.9.

Tenth Circuit: In *Fought*, 379 F.3d at 1005, the en banc court revised its conflict of interest approach because it recognized that the lack of concrete guidance afforded to district courts on the issue resulted in judicial confusion. "To say that there is a sliding scale of deference, however, merely begs the question: *how much* less deference ought a reviewing court afford? Our past opinions in this area do not clearly address this question. . . . Our failure to articulate clearly the requirements of a less deferential arbitrary and capricious standard has left district courts in this circuit without direction and has encouraged litigation." *Id.* at 1005. The court ultimately adopted another variation of the sliding scale test. First, the court stated that courts should consider a "standard" conflict of interest, i.e., a financial conflict, in determining whether there has been an abuse of discretion. *Id.* Next, the court considers whether there is (1) an inherent financial conflict of interest; (2) a proven conflict of interest "or (3) when a serious procedural irregularity exists, and the plan administrator has denied coverage." *Id.* at 1006. If so, "an additional reduction in deference is appropriate" and the administrator bears the burden of proving that its decision is reasonable and based on substantial evidence. *Id.* Although

the *Fought* court adopted a test that provides more guidance than the Tenth Circuit's prior approach, the court's new test still does not provide clear guidance as to how much a district court should reduce deference to a conflicted administrator.

B. The Smoking Gun Test.

In the Second Circuit, the plan participant must produce "smoking gun" evidence that proves that the administrator's decision was infected by the conflict of interest in order to receive anything but untempered abuse of discretion review. *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996) (holding that plaintiffs have the burden of proving that the conflict of interest affected the administrator's decision). This standard is in direct conflict to *Firestone's* instruction that a conflict of interest must be weighed as a "'facto[r] in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187); *see DeFelice v. Am. Int'l Life Assur. Co.*, 112 F.3d 61, 66 n. 3 (2d Cir. 1997) (criticizing *Sullivan* for ignoring *Firestone* by minimizing the effect of administrator's conflict of interest). In addition, because this standard requires the plaintiffs to *prove* that an administrator acted on a conflict, it places plaintiffs in an untenable position: on the one hand, plaintiffs bear the burden of proof of producing concrete evidence of conflicted decision-making, but on the other hand, plaintiffs are only permitted to seek evidence outside of the claims record where the plaintiff can demonstrate the

presence of "good cause" *in* the claims record to warrant discovery. *See Paese v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 441 (2d. Cir. 2006).

Beneficiaries have little chance of finding a "smoking gun" to prove that the administrator acted on a conflict. *See, e.g., Pinto*, 214 F.3d at 379. ("Our rule is also informed by the understanding that 'smoking gun' direct evidence of purposeful bias is rare in these cases so that, without more searching review, benefits decisions will be virtually immunized."). The Ninth Circuit rejected its previous standard requiring participants to produce such evidence, stating "[t]hat approach wrongly aligns incentives. Instead of being encouraged affirmatively to demonstrate their impartiality and the reasonableness of their decisions, plan administrators are rewarded for suppressing dissent and denying claims with as little explanation as possible." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006) (en banc). Consequently, it should not be the burden of the beneficiary "'to show that the fiduciary succumbed to this temptation, that he acted in bad faith, that he gained an advantage, fair or unfair, that the beneficiary is harmed.'" *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991), quoting *Fulton Nat'l Bank v. Tate*, 363 F.2d 562, 571-72 (5th Cir. 1966).

C. The Burden Shifting Test.

In the Eleventh Circuit, where there is a financial conflict of interest the court weighs the conflict by applying a de novo standard of review to the benefits decision, and then determines whether the fiduciary or administrator can demonstrate that its decision was not tainted by its financial self-interest. *Brown*, 898 F.2d at 1566-68. Under this approach, a court weighs the conflict of interest by determining whether, on de novo review, the administrator's decision is "wrong." *Id.* at 1567 n.12. If the decision is correct on de novo review, then the administrator's decision stands. If the decision would be wrong under a de novo review, the court further examines the conflict of interest. The direction to conduct a de novo review of the merits where there is a financial conflict of interest provides clear guidance to the lower courts for *how* to weigh the conflict, which is the very question posed time and time again by the sliding scale circuits.

Moreover, the Eleventh Circuit's standard conserves judicial resources, because it is only in those cases where the fiduciary's decision is wrong on de novo review that the court also must examine the seriousness of the conflict of interest and determine whether the fiduciary's decision is entitled to deference. If this Court adopts the Eleventh Circuit's approach of reviewing a benefits claim de novo where a financial conflict of interest is present unless the fiduciary can prove that the conflict did not affect the decision, most discovery

and motion practice regarding the standard of review would also be eliminated, and ERISA benefit litigation would be substantially streamlined. *See, e.g., Aguilar v. New United Motor Mfg., Inc. Disability Ins. Income Plan*, 2005 WL 2137784, *1 (N.D. Cal. Aug. 30, 2005) (where plan contained no grant of discretion, parties and court agreed at pre-trial conference that standard of review would be de novo; court did not consider evidence outside of the claim record and, following bench trial, ruled in favor of defendant); *McCoy v. Fed. Ins. Co.*, 7 F. Supp. 2d 1134, 1137 (E.D. Wash. 1998) (plan did not contain grant of discretion; case decided on motion for summary judgment without considering evidence outside of claim record).

D. The Credibility Determination with Clarifying Factors Test.

In *Abatie,* Ninth Circuit articulated its approach as "abuse of discretion review, tempered by skepticism commensurate with the plan administrator's conflict of interest." 458 F.3d at 959. Consistent with *Firestone*, 489 U.S. at 115, the Ninth Circuit instructed district courts to weigh any conflict of interest as a factor in abuse of discretion review:

> [W]eighing a conflict of interest as a factor in abuse of discretion review requires a case-by-case balance. . . . A district court, when faced with all the facts and circumstances, must decide in each case how much or how little to credit the plan administrator's

> reason for denying insurance coverage. An egregious conflict may weigh more heavily (that is, may cause the court to find an abuse of discretion more readily) than a minor, technical conflict might.

Abatie, 458 F.3d at 967, 968.

Although the Ninth Circuit acknowledged that its test was "substantially similar" to the "sliding scale" test used by the majority of Circuits, *id.* at 967, the court rejected the "sliding scale" metaphor and instead chose credibility determinations as a more apt analogy:

> [T]rial courts are familiar with the process of weighing a conflict of interest. For example, in a bench trial the court must decide how much weight to give to a witness' testimony in the face of some evidence of bias. What the district court is doing in an ERISA benefits denial case is making something akin to a credibility determination about the insurance company's or plan administrator's reason for denying coverage under a particular plan and a particular set of medical and other records.

Id. at 969. Just as evidence of bias can undercut the credibility of a witness' testimony, evidence of a conflict of interest may belie an insurance company's stated reasons for denying a claim. *See Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987) (Posner,

J.) (when trustees "have a serious conflict of interest, the proper deference to give their decisions may be slight, even zero; the decision if wrong may be unreasonable").

The *Abatie* decision responds to criticism of the sliding scale test as too vague by supplying much-needed guidance and examples to the district courts. The Ninth Circuit's approach is an improvement upon the sliding scale test because it provides categories of evidence that the courts should consider in deciding whether a claims fiduciary was influenced by a conflict of interest and how different types of conflicts should affect the judicial standard of review.

In *Abatie*, the Ninth Circuit listed numerous examples of evidence that might cause a court to weigh a conflict more heavily: "evidence of malice, of self-dealing, or of a parsimonious claims-granting history." 458 F.3d at 968. Further examples include where "the administrator provides inconsistent reasons for denial; fails adequately to investigate a claim or ask the plaintiff for necessary evidence; fails to credit a claimant's reliable evidence; or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record." *Id.* at 968-69.

The Ninth Circuit also suggested factors that may ameliorate a fiduciary's conflict of interest: the administrator could demonstrate that it used

"truly independent medical examiners or a neutral, independent review process; that its employees do not have incentives to deny claims; that its interpretations of the plan have been consistent among patients; or that it has minimized any potential financial gain through structure of its business (for example, through a retroactive payment system)." *Id.* at 969 n. 7. Conversely, if a participant can show that a claims fiduciary failed to take these precautions, then a court may weigh the conflict more heavily.

The *Abatie* court's approach also gives district courts the flexibility necessary to account for the variety of administrative schemes found in ERISA plans. Although an insurance company acts as claims administrator and pays disability benefits out of its own assets under most disability plans (including the plan in the present case), different arrangements which present less risk of financial conflicts of interest are common in other types of ERISA plans.

For example, ERISA requires that pension plan assets be held in trust[5] and pension plans are

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[5]"ERISA requires a plan's combined assets to be held in trust and legally owned by the plan trustees." *LaRue v. DeWolff, Boberg & Associates, Inc.*, —U.S.—, 128 S. Ct. 1020, 1029 (2008) (Thomas, J. concurring), *citing* ERISA § 403(a), 29 U.S.C. § 1103(a). ERISA's trust requirement does not apply to plans providing benefits through insurance policies. ERISA § 403(b)(1); 29 U.S.C. § 1103(b)(1).

typically administered by a plan committee composed of company employees. Since the pension trust assets can "never inure to the benefit of any employer," ERISA § 403(c)(1), 29 U.S.C. § 1103(c)(1), the typical pension plan's administrative scheme poses less risk of financial conflicts of interest than an insurance company's incentive to minimize claims payments from its own assets. If the entity making the claims decision is not responsible for paying benefits, it is less likely to have a financial conflict of interest. *See Pinto*, 214 F.3d at 383; *see also Fought*, 379 F.3d at 1005.[6]

The credibility determination required by *Abatie* permits the courts to make a common-sense decision as to whether the claims fiduciary acted properly. The courts have heard insurance disputes similar to the present case for centuries and are experienced in deciding whether an insurance coverage denial is justified or in bad faith. The fact that the present case arose in the

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[6]However, as noted by the concurring opinion in *Abatie*, "A so-called independent administrator may have much more of an incentive to decide against claimants than an insurance company spending 'its own money.' Independent administrators may want to show how tough they are on claims to better market their services to self-insured employers." 458 F.3d at 977 (Kleinfeld, J. concurring). Therefore, courts need to consider a third-party administrator's compensation arrangements and incentives before assuming that a third-party administrator has no financial self-interest.

context of an ERISA plan does not change the fact that the underlying dispute is an insurance coverage claim. *See generally* NAIC Amicus Br.

V. THIS COURT SHOULD IMPROVE UPON *ABATIE* BY ADOPTING THE RESTATEMENT OF TRUST'S "ESPECIALLY CAREFUL SCRUTINY" TEST AND PROVIDING THE LOWER COURTS WITH ADDITIONAL GUIDANCE SPECIFIC TO ERISA CLAIMS.

The *Abatie* court's credibility determination test is an improvement upon the "sliding scale" standard because the Ninth Circuit gave specific examples of evidence showing a serious conflict of interest to guide the lower courts. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 968-69 (9th Cir. 2006) (en banc). Nevertheless, the *Abatie* court's holding falls short of the trust law standard for a conflicted fiduciary. Instead, this Court should adopt the standard suggested by Restatement (Third) of Trusts for a dual-role administrator: when a "beneficiary serves as a trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." § 37, cmt. f(1).[7]

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[7]The Eleventh Circuit's burden shifting test is the simplest and most efficient method for the courts to evaluate decisions made by dual-role administrators; however, some courts have criticized the test as being

(footnote continued...)

Amicus agrees with Respondent that the trust law requirement of "especially careful scrutiny" mandates closer scrutiny of a conflicted trustee's actions than the baseline requirement of reasonableness for an unconflicted trustee's actions. The reviewing court must satisfy itself that the conflict did not impermissibly affect the dual-role insurer's decision, whether consciously or unconsciously.

Although the "especially careful scrutiny" standard is appropriate as the default standard of review for a dual-role administrator, the courts should apply a stricter standard of review if there is additional evidence that the claim decision was tainted by a conflict of interest. As the Ninth Circuit did in *Abatie*, the Court should take this opportunity to provide the lower courts with

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(continued from previous page)
inconsistent with *Firestone*. *See Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826 (10th Cir. 1996). However, if this Court decides otherwise, then the Eleventh Circuit's approach is best-suited for protecting the benefit rights of plan participants. *See* John H. Langbein, *Trust Law As Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315, 1334 (2007) ("The Supreme Court could, without confessing error in *Bruch*, materially reduce the scope of *Bruch's* mischief by resolving this conflict among the circuits in favor of the position of the Eleventh Circuit, insisting on de novo review despite contrary plan terms in cases involving conflicted decisionmaking.").

guidance as to factors that result in a stricter standard of review than "especially careful scrutiny."

In weighing evidence of a claims administrator's conflict of interest, the courts should consider "both structural and procedural factors." *Post v. Hartford Ins. Co.*, 501 F.3d 154, 162 (3d Cir. 2007), *citing Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 192-93 (3d Cir. 2000). Certain structural conflicts and procedural violations are so at odds with ERISA's requirement that administrators provide participants with a "full and fair review," ERISA § 503, 29 U.S.C. § 1133, that these factors should result in the courts giving little or no deference to the administrator's claim denial. *See, e.g., Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 511 F.3d 1206, 1216-17 (9th Cir. 2008) (noting that, under *Abatie*, the lower court should determine "the degree of deference (*if any*) it should accord MetLife's decision") (emphasis added).

Although the following list is not exhaustive, amicus believes that little or no judicial deference should be given to a dual-role administrator where any of these four factors is present.

A. The Courts Should Review the Claim Denial de Novo Where a Dual Role Administrator Violates the Secretary of Labor's Claim Procedure Regulations.

The courts should review de novo claim denials in cases where the administrator violates the

requirements contained in the Secretary of Labor's Claims Procedure Regulations, 29 C.F.R. § 2560.503-1, promulgated pursuant to ERISA § 503, 29 U.S.C. § 1133. The Regulations "set[] forth the minimum requirements for employee benefit plan procedures pertaining to claims for benefits, " 29 C.F.R. § 2560.503-1(a), in order to provide claimants with a "full and fair review" as required by 29 U.S.C. § 1133(2). Many of the rules set forth in the Regulations are also required to be included in the Summary Plan Description (SPD), the plan document which plan administrators are required to provide to plan participants. ERISA § 102, 29 U.S.C. § 1022 ("[t]he summary plan description shall contain . . . the procedures to be followed in presenting claims for benefits under the plan . . .").

A violation of the Regulations or the SPD is akin to a trustee violating the terms of the trust document. In such instances, the courts do not give any deference to the decisions of the trustee. For example, in *Valma M. Hanson Revocable Trust*, 779 N.E.2d 1218, 1220-23 (Ind. App. 2002), the court held that the beneficiaries had stated a cause of action in alleging that the trustee had violated the terms of the trust, rejecting the trustee's arguments that his actions were within his discretionary authority as trustee. Similarly, the Second Circuit and other circuits have held that a "deemed denial" of a benefit claim resulting from a claim fiduciary's failure to decide a claim within the time frame required by the Regulations and/or plan documents is not entitled to discretionary review. *Nichols v. Prudential Ins. Co. of Am.*, 406

F.3d 98, 109 (2d Cir. 2005). *See also Abatie*, 458 F.3d at 971 ("[F]lagrant" violations of the Department of Labor Regulations will result in *de novo* review."); *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1106-07 (9th Cir. 2003); *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 632-33 (10th Cir. 2003); *Gritzer v. CBS, Inc.*, 275 F.3d 291, 295 (3d Cir. 2002).

B. The Courts Should Give Little or No Deference to Claims Administrators Who Seek to Thwart Claimants by Changing Their Reasons for Denying a Claim.

In addition, the courts should give little or no deference to a claim denial where the claim fiduciary changes its reason for denying the claim. Many courts have criticized insurance companies that seek to frustrate claimants by changing the basis for a claim denial when the claimant presents evidence that the initial basis for denying the claim was wrong:

> [T]he fact that the claims administrator presented a new reason at the last minute bears on whether denial of the claim was the result of an impartial evaluation or was colored by MetLife's conflict of interest. After all, coming up with a new reason for rejecting the claim at the last minute suggests that the claim administrator may be casting about for an excuse to reject the claim rather than conducting an objective evaluation.

Saffon, 511 F.3d at 1215. *See also, Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998) ("We will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation"); *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 799 (9th Cir. 1997) (de novo review where claim fiduciary provides inconsistent reasons for denial under former Ninth Circuit standard). The failure to provide a claim review process that permits the participant to respond to all of the administrator's reasons for rejecting his claim is adversarial conduct that warrants de novo review.

C. The Courts Should Give Little or No Deference to Claim Denials Based on Reports by Biased Medical Evaluators.

The court should give little if any deference to claim denials based on reports by biased physicians. As shown by *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), a key issue in disability benefit claims is the reliability of medical evidence. In *Nord*, this Court rejected adoption of the treating physician rule for ERISA disability benefit claims. *Id.* at 830-31. However, the Court expressed "concern that physicians repeatedly retained by benefits plans may have an incentive to make a finding of 'not disabled' in order to save their employers money and to preserve their own consulting arrangements." *Id.* at 1143 (quotation

omitted). For example, in *Hangarter v. Provident Life & Accident Insurance Co.*, 373 F.3d 998, 1011 (9th Cir. 2004), the court discounted the testimony of a physician hired by the insurer in a non-ERISA case where evidence obtained in discovery showed that the physician rejected insureds' disability claims in thirteen out of thirteen cases. In *Bennett v. Unum Life Insurance Co. of America,* 321 F. Supp. 2d 925, 933-36 (E.D. Tenn. 2004), the court recited evidence detailing how the insurer pressured claims adjusters and medical reviewers to deny claims to increase profits. *See also Abatie*, 458 F.3d at 969 n.7 ("a conflicted administrator, facing closer scrutiny, may find it advisable to bring forth affirmative evidence that any conflict did not influence its decision making process . . . [f]or example, the administrator might demonstrate that it used truly independent medical examiners . . . ."). If an administrator cannot show that its medical review process was neutral, the court should not be obligated to defer to its decision.

D. The Courts Should Give Little or No Deference to Claim Denials Where the Insurer Has a Parsimonious Claims Granting History.

Finally, where an insurer has a history of denying meritorious claims, courts should be permitted to review subsequent denied claims neutrally, on de novo review, rather than forced to defer to an administrator with a demonstrated bias. *See Abatie*, 458 F.3d at 968. For example, in *Radford Trust v. First Unum Life Insurance Co.*,

the court found that the case "is not the first time that First Unum has sought to avoid its contractual responsibilities, and an examination of cases involving First Unum . . . reveals a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics." 321 F. Supp. 2d 226, 247 (D. Mass. 2004), *rev'd on other grounds*, 491 F.3d 21 (1st Cir. 2007); *see also* John H. Langbein, *Trust Law As Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 N.W. U. L. REV. 1315, 1317-21 (2007).

CONCLUSION

For the reasons stated above, this Court should uphold the decision below.

Respectfully submitted,

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APPENDIX

STATUTORY APPENDIX

29 C.F.R. § 2560.503-1(a):

Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

ERISA § 102, 29 U.S.C. § 1022:

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 1191b(a)(1) of this title), whether a health insurance issuer (as defined in section 1191b(b)(2) of this title) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different

from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this chapter and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 1191b(a)(1) of this title) and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

ERISA § 403, 29 U.S.C. § 1103:

(a) Benefit plan assets to be held in trust; authority of trustees

Except as provided in subsection (b) of this section, all assets of an employee benefit plan shall be held in trust by one or more trustees. Such trustee or trustees shall be either named in the trust instrument or in the plan instrument described in section 1102(a) of this title or appointed by a person who is a named fiduciary, and upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan, except to the extent that--

(1) the plan expressly provides that the trustee or trustees are subject to the direction of a named fiduciary who is not a trustee, in which case the trustees shall be subject to proper directions of such fiduciary which are made in accordance with the terms of the plan and which are not contrary to this chapter, or

(2) authority to manage, acquire, or dispose of assets of the plan is delegated to one or more investment managers pursuant to section 1102(c)(3) of this title.

(b) Exceptions

The requirements of subsection (a) of this section shall not apply--

(1) to any assets of a plan which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State;

(2) to any assets of such an insurance company or any assets of a plan which are held by such an insurance company;

(3) to a plan--

(A) some or all of the participants of which are employees described in section 401(c)(1) of Title 26; or

(B) which consists of one or more individual retirement accounts described in section 408 of Title 26;

to the extent that such plan's assets are held in one or more custodial accounts which qualify under section 401(f) or 408(h) of Title 26, whichever is applicable.

(4) to a plan which the Secretary exempts from the requirement of subsection (a) of this section and which is not subject to any of the following provisions of this chapter--

(A) part 2 of this subtitle,

(B) part 3 of this subtitle, or

(C) subchapter III of this chapter; or

(5) to a contract established and maintained under section 403(b) of Title 26 to the extent that the assets of the contract are held in one or more custodial accounts pursuant to section 403(b)(7) of Title 26.

(6) Any plan, fund or program under which an employer, all of whose stock is directly or indirectly owned by employees, former employees or their beneficiaries, proposes through an unfunded arrangement to compensate retired employees for benefits which were forfeited by such employees under a pension plan maintained by a former employer prior to the date such pension plan became subject to this chapter.

(c) Assets of plan not to inure to benefit of employer; allowable purposes of holding plan assets

(1) Except as provided in paragraph (2), (3), or (4) or subsection (d) of this section, or under sections 1342 and 1344 of this title (relating to termination of insured plans), or under section 420 of Title 26 (as in effect on August 17, 2006), the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.

(2)(A) In the case of a contribution, or a payment of withdrawal liability under part 1 of subtitle E of subchapter III of this chapter--

(i) if such contribution or payment is made by an employer to a plan (other than a multiemployer plan) by a mistake of fact, paragraph (1) shall not prohibit the return of such contribution to the employer within one year after the payment of the contribution, and

(ii) if such contribution or payment is made by an employer to a multiemployer plan by a mistake of fact or law (other than a mistake relating to whether the plan is described in section 401(a) of Title 26 or the trust which is part of such plan is exempt from taxation under section 501(a) of Title 26), paragraph (1) shall not prohibit the return of such contribution or payment to the employer within 6 months after the plan administrator determines that the contribution was made by such a mistake.

(B) If a contribution is conditioned on initial qualification of the plan under section 401 or 403(a) of Title 26, and if the plan receives an adverse determination with respect to its initial qualification, then paragraph (1) shall not prohibit the return of such contribution to the employer within one year after such determination, but only if the application for the determination is made by the time prescribed by law for filing the employer's return for the taxable year in which such plan was adopted, or such later date as the Secretary of the Treasury may prescribe.

(C) If a contribution is conditioned upon the deductibility of the contribution under section 404

of Title 26, then, to the extent the deduction is disallowed, paragraph (1) shall not prohibit the return to the employer of such contribution (to the extent disallowed) within one year after the disallowance of the deduction.

(3) In the case of a withdrawal liability payment which has been determined to be an overpayment, paragraph (1) shall not prohibit the return of such payment to the employer within 6 months after the date of such determination.

(d) Termination of plan

(1) Upon termination of a pension plan to which section 1321 of this title does not apply at the time of termination and to which this part applies (other than a plan to which no employer contributions have been made) the assets of the plan shall be allocated in accordance with the provisions of section 1344 of this title, except as otherwise provided in regulations of the Secretary.

(2) The assets of a welfare plan which terminates shall be distributed in accordance with the terms of the plan, except as otherwise provided in regulations of the Secretary.

ERISA § 503, 29 U.S.C. § 1133:

In accordance with regulations of the Secretary, every employee benefit plan shall--

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

65 Fed. Reg. 70246, 70263 (Nov. 21, 2000):

The Department considered the following major actions that plans (or their service providers) would undertake to come into compliance with the regulation: revising processes, revising forms, modifying systems, and hiring or contracting where necessary. The Department assumed that all health and disability plans would have to revise processes and forms and modify systems to at least some degree and that some would hire personnel or contract for additional or different services in order to achieve compliance. [FN55]

FN55 This estimate is not intended to include the cost of developing new explanations of claims processes for inclusion in plan descriptions. The Department separately accounts for that cost as part of the estimated cost of its regulation governing the content of summary plan descriptions.

4. Ongoing Costs

In estimating the ongoing cost of various provisions, the Department considered the number of claims transactions to which they apply, the degree to which plans already comply in the course of normal business or in response to a state law or other mandate other than ERISA, and, to the degree that they do not, the likely cost of coming into compliance.
Claims volume was estimated by applying

estimated claiming rates for various types of claims to projected estimates of plan enrollment in 2002. To estimate the application of the regulation's various requirements to different types of benefit claims, it was necessary to separately estimate health, disability, pension, and other benefit claims volumes. With respect to health benefit claims, it was necessary to separately estimate urgent, pre-service, and post-service claims volume, and the number of denials that are based on clinical or medical judgments. With respect to disability claims, it was necessary to estimate short-term and long-term disability claims separately. The Department also accounted separately for costs associated with approved and denied claims and appeals. Table 4 summarizes estimated 2002 claims volume.

Table 4.--
Summary of Claims Volume, 2002

	Health (MMs)	Disability (000s)	Pension (000s)	Other (000s)
Claims	1,369.7	1,389.7	2,122.1	244.5
Approved	1,328.6	1,304.9	2,104.0	236.4
Denied	41.0	84.8	18.0	8.1
Appeals	0.4	31.6	1.8	0.8
Approved	0.3	6.5	0.9	0.4
Denied	0.1	25.1	0.9	0.4
Health claims (MMs)	1,369.7			
Urgent pre-service	1.2			
Routine pre-service	40.0			
Post-service	1,328.5			

Denied health claims (MMs)	41.0			
Clinical/scientific basis	14.5			
Other basis	26.5			
Disability claims (000s)	1,389.7			
Short-term	1,162.7			
Long-term	227.1			

The Department applied estimates of health and disability benefit claiming rates and claims mix to its estimates of enrollment in health and disability plans to produce its estimates of total claims volume. The Department estimated claims volume and mix in light of comments received in response to its proposed regulation and other data that provide reasonable proxies for private-sector employment-based health and disability benefit plans' claim patterns. For example, comments on the proposed regulation indicated health benefit claiming rates ranging from about 5 to 18 claims per individual per year. The average rate across all comments reporting rates was 9 claims per year, and surveys available to the Department reported rates of 6 [FN56] and 11 [FN57] claims per year. Many of these reported figures may omit some health benefit claims, such as dental claims, made by the same individuals under separate plans. The Department assumed that the health benefit claiming rates average 10 per covered individual, believing that this is consistent with comments received and other available information.

FN56 A published 1995 survey of 53 health insurers' claims systems by the Health Insurance Association of America.

FN57 A survey of 7 managed care organizations conducted and provided to the Department in response to its proposed regulation.
The Department similarly relied on comments received and other available data to assess health benefit claims denial and appeal rates and the mix of urgent, pre- and post-service claims. The Department assessed disability claiming rates and claims mix based on comments received (including information from the life insurance industry) and available data on the incidence of temporary and permanent disability in the working age population. [FN58]

FN58 Primarily, data from the National Center for Health Statistics and the Social Security Administration.
The Department separately considered the effect of each of the regulation's major provisions on each type of claim to which it applies. Based on its analysis, the Department attributed cost to the application of the regulation's notice, timeliness, disclosure, standard of review, and expert consultation requirements to health and disability claims and appeals.

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In The

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF FOR NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*[1]

The National Association of Insurance Commissioners ("NAIC") is a non-profit corporation whose membership consists of the principal insurance regulatory officials of the fifty States, the District of Columbia, the territories and insular possessions of the United States. Founded in 1871, it is the nation's oldest association of state government officials. The NAIC represents the coordinated and considered views of the state government officials that regulate and enforce the insurance laws of the country.

The NAIC's purpose is to provide its members with a national forum enabling them to work cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions. Collectively, the state insurance commissioners work to develop model legislation, rules, regulations, white papers and actuarial guidelines that promote and establish uniform regulatory policy. Their overriding objectives are to protect consumers as well as assist in maintaining the financial stability of the insurance industry.

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[1] No counsel for a party authorized this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission. Counsel of record for all parties received notice at least ten days prior to the due date of the *amicus curiae's* intention to file this brief. Counsels for Petitioners and Respondent have submitted letters to the Clerk of the Court consenting to the filing of all *amicus* briefs in this case.

The NAIC performs numerous crucial services on behalf of state governments including: developing and publishing model laws, regulations, bulletins, financial and accounting standards, white papers, consumer guides, handbooks, periodicals and the *Proceedings of the NAIC*. Hundreds of state and federal laws assign duties to the NAIC and incorporate NAIC standards, models and other publications. In addition, the NAIC manages and coordinates the accreditation review of insurance departments as well as maintains regulatory and financial databases of insurance company financial data.

The interest of the NAIC in this case arises out of the regulatory responsibility vested in each commissioner over health insurance and disability income protection coverage. The insurance commissioners of the various states are charged by state and federal law with the responsibility of regulating the business of insurance within their respective jurisdictions pursuant to the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011, *et seq.* ("McCarran-Ferguson Act"), and state insurance laws. The authority to regulate insurance issued in connection with employee welfare benefits plans is reserved to the states through the savings clause of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"). 29 U.S.C. § 1144(b)(2)(A).

The Court granted limited certiorari to hear this case on the questions of (1) whether a claim administrator of an ERISA plan that also funds the plan benefits (sometimes referred to as a "dual-role

administrator"), without more, has a conflict of interest which must be weighed in a judicial review of the administrator's benefit determination; and (2) if this is in fact a conflict, how that conflict should be taken into account on judicial review of a discretionary benefit determination. *MetLife v. Glenn*, 128 S.Ct. 1117 (2008). The specific ERISA plan at issue in this case provided benefits through a long-term disability insurance policy containing the following discretionary clause:

> In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have the discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. J.A. 148a, 181a.

The NAIC adopted the Prohibition on the Use of Discretionary Clauses Model Act, 1 NAIC *Model Laws, Regulations and Guidelines,* 42-1 to 42-6 (2002, amended 2004) ("Discretionary Clause Model Act"), that bans discretionary clauses in health insurance and disability income protection coverage partly because of the inherent conflict of interest that exists when an insurer responsible for providing benefits has discretionary authority to decide what benefits are due.

The Executive Committee of the NAIC voted to file this *amicus* brief to emphasize the need for sound regulation and judicial review when the benefit payor makes its own determinations on benefit claims. Through the passage of the Discretionary Clauses Model Act, the NAIC and its members have made the policy determination that the best way to address this conflict from a public policy perspective is to prevent it. By removing discretionary clauses from insurance policies, state insurance regulators assure that disputes concerning health insurance benefits and disability income protection coverage are resolved fairly, based on evidence; state insurance regulators also eliminate the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due.

Despite the NAIC model, many policies that contain discretionary clauses remain on the market. In such cases, should claim denials be reviewed deferentially? Because of the conflict of interest inherent in such claims review, the NAIC would answer, "No." Application of a *de novo* standard of review would promote fair claims handling practices and place the rights and duties of the parties in a group setting on the same footing with the rights and duties of the parties in all other insurance proceedings.

SUMMARY OF ARGUMENT

The Court of Appeals correctly held that Petitioner MetLife (Metropolitan Life Insurance Company) acted under a conflict of interest and its decision to deny long-term disability benefits to Respondent Wanda Glenn was not the product of a principled and deliberative reasoning process. The questions to be addressed by the Court on certiorari raise several issues that are of general and national concern to the membership of the NAIC:

1. In approving the Discretionary Clauses Model Act, the NAIC has made a policy determination that there is an inherent conflict of interest with respect to health insurance and disability income protection coverage that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. Recognition by the Court of this policy consideration would resolve the current split between the Circuits by adopting the reasoning of the Sixth Circuit that a plan administrator that both funds and administers the plan acts in a dual function that creates an inherent conflict of interest. *Glenn v. MetLife,* 461 F.3d 660, 666 (6th Cir. 2006).

2. Petitioners argue that the realities of the insurance business confirm that a company that evaluates and pays claims does not operate under a conflict of interest which must be weighed on judicial review. However, the 2004 multistate market conduct examination conducted with respect to disability

claims handled by UnumProvident Corporation ("Unum"), in which Unum agreed to a $140 million settlement and a $15 million penalty, provides ample evidence that these conflicts are real and must be recognized by the Court.

3. If the Court recognizes that the conflict of interest is inherently present when the administrator is the insurer on risk for the claim, a *de novo* standard of review should be used to review claim denials (despite any discretionary clause). Application of this standard is necessary to promote fair claims handling practices and place the rights and duties of the parties in a group setting on the same footing with the rights and duties of the parties in all other insurance proceedings.

4. When the administrator is the insurer on risk for the claim, the Court should reconsider its decision that abuse-of-discretion review applies if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The analogy to trust law on which the Court based this portion of its decision is unsound in these circumstances, and it is contrary to the protective intent of ERISA to allow plan drafters to dictate reduced scrutiny for conflicted plan fiduciaries in contested insurance benefit denial cases.

ARGUMENT

1. THERE IS AN INHERENT CONFLICT OF INTEREST WHEN THE DUAL-ROLE INSURANCE CARRIER HAS DISCRETIONARY AUTHORITY TO DECIDE WHAT BENEFITS ARE DUE.

ERISA was enacted to "protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of [those] plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). As part of ERISA's comprehensive enforcement scheme, § 502(a)(1)(B) authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B).

In *Firestone*, the Court considered the appropriate standard of review in an action to recover benefits under an ERISA plan. *Firestone* held that courts would presumptively review ERISA benefit determinations *de novo,* but stated that "a deferential standard of review [is] appropriate" when the decisionmaker is given "discretionary powers." *Firestone*, 489 U.S. at 115. If the plan documents expressly give the administrator discretionary authority, then the administrator's decisions are final and could be challenged only for abuse of discretion, *i.e.*, if the administrator's decision was arbitrary and capricious. In general, under *Firestone* judicial deference is accorded to the decisions of administrators who have

been given discretionary authority. *See Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1089 (9th Cir. 1999). In light of *Firestone*, the standard industry practice has been to include discretionary clauses in insurance contracts to ensure that a court uses a deferential standard of review, except where such clauses are prohibited by state law.

The Court in *Firestone* tempered its decision by noting that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). Since the *Firestone* decision in 1989, the circuits have struggled to construe this command, and apply it to benefit decisions by insurance carriers which, by definition, labor under a structural conflict of interest. The circuits disagree both on whether conflicted decision-making by insurers may be presumed or must be proven through direct evidence of taint, and on how to take any conflict into account in reviewing insurance company decisions.

The *amicus* brief of the United States filed by the Solicitor General in this case on petition for writ of certiorari provides an excellent discussion of the circuit split on the first question presented by this Court; i.e., whether the fact that a claim administrator of an ERISA plan also funds the plan benefits, without more, constitutes a conflict of interest which must be weighed in a judicial review of the administrator's

benefit determination. U.S. *Amicus* Br. 7-8. Without providing an in-depth analysis of the position of each circuit and the authority upon which it relies, the NAIC encourages this Court to adopt the position taken by the Sixth Circuit that a plan administrator that both funds and administers the plan is performing a dual function that creates an apparent conflict of interest. *See Glenn,* 461 F.3d at 666.

The Sixth Circuit explained the basis for the approach taken in *Glenn* in a prior decision, reasoning that a plan administrator that both funds and administers the plan operates under a direct conflict because it has a financial incentive to deny benefits because it "incurs a direct expense as a result of the allowance of benefits," and it "benefits directly from the denial or discontinuation of benefits." *Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (6th Cir. 1998). U.S. *Amicus* Br. 7.

The NAIC originally passed the Discretionary Clauses Model Act in 2002 prohibiting the use of discretionary clauses in health insurance policies. 1 Proc. of the Nat'l Ass'n of Ins. Comm'rs 4, 12-13 (2002). Among the reasons cited were that the NAIC membership believed that discretionary clauses were inconsistent with basic insurance consumer rights. 4 Proc. of the Nat'l Ass'n of Ins. Comm'rs 2290 (2003). The stated purpose of the Model Act was to assure that the reasonable expectations of the claimant would be protected under an objective, contract-based standard for claims. Prohibition on the Use of Discretionary Clauses Model Act, Technical Amendment

and Project History. 2 Proc. of the Nat'l Ass'n of Ins. Comm'rs 10, 17 (2002).

In 2004 the NAIC extended this prohibition to disability insurance. 4 Proc. of the Nat'l Ass'n of Ins. Comm'rs 57 (2004). In addition to the rationale cited above, the NAIC considered the long-standing principle that any ambiguities in an insurance policy must be interpreted in favor of the insured person. Currently 11 states (California, Hawaii, Illinois, Indiana, Michigan, Maine, Montana, New Jersey, New York, Oregon and Utah) have adopted some type of prohibition against discretionary clauses in either health (sometimes called "disability" or "accident and sickness" coverage in insurance codes) or disability income insurance policies.[2] Recent District Court

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[2] *See* ME. REV. STAT. ANN. tit. 24-A § 4303 (1995); ILL. ADMIN. CODE tit. 50, § 2001.3 (2005); MICH. ADMIN. CODE r. 500.2201-2202 (2007); N.J. ADMIN. CODE § 11:4-58 (2007); UTAH ADMIN. CODE r. 590-218 (2003); *Am. Counc. of Life Ins. v. Watters*, 2008 WL 541654 (W.D. Mich. 2008); *Standard Ins. Co. v. Morrison*, 2008 WL 510043 (D. Mont. 2008); Notice, Cal. Dep't of Ins., Notice to Withdraw Approval and Order for Information (Feb. 27, 2004), *available at* www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/Notice-February-27-2004.pdf (last visited Mar. 26, 2008); Commissioner's Memorandum 2004-13H from the Hawaii Dep't of Ins. On Discretionary Clauses in HMSA's Agreement for Group Health Plan and Guide to Benefits (Dec. 8, 2004), *available at* http://hawaii.gov/dcca/areas/ins/commissioners_memo/ (last visited Mar. 26, 2008); Bulletin 103 – Full and Final Discretion Clauses in Group Health Contracts (Ind. Dep't of Ins. June 8, 2001), *available at* http://www.in.gov/idoi/lookAtTheLaw/pdfs/Bulletin 103.pdf (last visited Mar. 26, 2008); Circular Letter No. 14 (State of N.Y. Ins. Dep't June 29, 2006), *available at* www.ins.state.ny.

(Continued on following page)

decisions in Montana and Michigan confirm that rules prohibiting discretionary clauses in insurance policies sold in these states were saved from preemption as laws regulating insurance under ERISA's savings clause. *See Am. Counc. of Life Ins. v. Watters*, 2008 WL 541654 (W.D. Mich. 2008); *Standard Ins. Co. v. Morrison*, 2008 WL 510043 (D. Mont. 2008).

The NAIC's members develop model laws and regulations to serve as standards for the promulgation of insurance laws and regulations in individual states. Consistent with its mission, the NAIC helps its members and their respective insurance departments explain the function and significance of NAIC model laws and regulations to legislatures, courts, other divisions of the executive branch, industry, consumers and the general public. The public policy behind the NAIC's Discretionary Clauses Model Act is clearly stated in *Section 2. Purpose and Intent*:

> The purpose of this Act is to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. Nothing in this Act shall be construed as

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us/cl06_14.htm (last visited Mar. 26, 2008); Standard Provisions for Long and Short Term Disability Group or Individual (Or. Ins. Div. Apr. 5, 2005), *available at* www.oregoninsurance.org/docs/serff/2447.pdf (last visited Mar. 26, 2008).

> imposing any requirement or duty on any person other than a health carrier or insurer that offers disability income protection coverage.

The U.S. Congress charged state insurance commissioners with great responsibility in enacting the McCarran-Ferguson Act by reserving to the states the authority to regulate the business of insurance. NAIC members have acted accordingly in adopting the Discretionary Clauses Model Act, which recognizes that there is an inherent conflict of interest in dual role administrators. This Court should give due deference to the collective experience of the members of the NAIC who are entrusted to regulate disability income protection insurance coverage, and find that a claim administrator of an ERISA plan that also funds the plan benefits constitutes a conflict of interest which must be weighed in a judicial review of the administrator's benefit determination. Accordingly, this Court should affirm the opinion of the Sixth Circuit in this matter finding that Respondent had an apparent conflict of interest in this case.[3]

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[3] The case currently before this court involves a discretionary clause in a group long term disability policy, over which the NAIC members have jurisdiction under the McCarran-Ferguson Act and the ERISA savings clause. 29 U.S.C. § 1144(b)(2)(A). The NAIC's Discretionary Clauses Model Act similarly only addresses disability insurance policies, and not self-funded plans or administrative services supplied to self-funded plans by disability insurance carriers. Therefore, the NAIC does not express an

(Continued on following page)

2. PETITIONERS' ARGUMENT THAT THE REALITIES OF THE INSURANCE BUSINESS CONFIRM A COMPANY THAT BOTH EVALUATES AND PAYS CLAIMS DOES NOT OPERATE UNDER A CONFLICT OF INTEREST IS CONTRADICTED BY THE UNUM MULTISTATE EXAMINATION.

In support of their argument that a company that pays claims does not, for that reason alone, operate under a conflict of interest that must be weighed on judicial review, Petitioners argue that the realities of the insurance business confirm such a dual-role company does not operate under a conflict of interest. Pet'r Br. 29. Petitioners argue any potential conflict inherent in an insurance company's evaluation and payment of claims is counterbalanced by the fact that insurers have powerful long-term business incentives to treat claimants fairly. Pet'r Br. 29-33.

The Petitioner's arguments are not new to either insurance regulators or the courts, and at least one commentator has referred to them as "deeply flawed." John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA*, 101 NW. U. L. REV. 1315, 1327 (Spring 2007). Prof. Langbein goes on to refute each of Petitioners' arguments, addressing them through both legal theory and real life experience. For

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opinion to the Court on the effect of discretionary clauses in self-funded ERISA disability plans.

example, with respect to Petitioners' argument comparing an insurance company claim administrator with a social security examiner (Pet'r Br. 32), Prof. Langbein cites to *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000), in which the court observed that the Social Security Administration "is a public agency that denies benefits only after giving the applicant an opportunity for a full and fair adjudicative hearing. The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by [ERISA] plan administrators."

However, the best real-life example provided by Prof. Langbein is a matter that is very familiar to the NAIC and its members: The Report of the Targeted Multistate Disability Income Market Conduct Examination (Feb. 29, 2004) ("Unum Multistate Examination Report").[4]

Unum/Provident Corporation ("Unum"), the largest disability insurance company in the United States, had been the target of nearly 3,000 lawsuits, in addition to a 2002 class action suit alleging that Unum was unfairly and deliberately denying disability claims. Many federal courts have commented on Unum's aggressive claims denial practices during this time, speaking about Unum's selective review of the administrative record, lack of objectivity, abuse of discretion, misuse of ambiguous test results, and

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[4] *Available at* http://maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (last visited Mar. 26, 2008).

claims evaluation practices that defied common sense and bordered on outright fraud. Langbein, 101 NW. U. L. REV. at 1320.

The NAIC coordinated a multistate market conduct examination by its members starting in 2003, focusing on Unum claims practices. In November 2004, Unum (without admitting, denying or conceding any actual or potential fault) signed an agreement with the insurance commissioners of Massachusetts, Maine, and Tennessee in which Unum settled allegations related to systematic irregularities found in its claim handling practices for both individual and group disability claims. *See* Unum Multistate Examination Report at Paragraph C.12. Forty-seven other states and the District of Columbia joined the three lead states in the multistate market conduct examination of Unum Life Insurance Company of America, The Paul Revere Life Insurance Company, and Provident Life and Accident Insurance Company. The U.S. Department of Labor, which conducted a related investigation of Unum's practices involving employee benefit plans covered by ERISA, was also a party to the settlement, and New York's Attorney General also endorsed the settlement. *See* Joint Press Release, Multi-State Settlement Addresses Concerns Regarding Unum-Provident Claims Handling (Nov. 18, 2004) ("Multistate Settlement Announcement").[5]

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[5] *Available at* http://www.state.tn.us/commerce/pdf/press/prsRls111804.pdf (last visited Mar. 26, 2008).

The Unum Multistate Examination Report, which was issued after Unum had lost several high-profile disability claim cases, included a $140 million settlement and a $15 million fine against Unum. California, which settled separately with Unum, imposed an additional $8 million civil penalty. California Settlement Agreement, File No. DISP05045984.[6] The Multistate Settlement Announcement identified several claims handling practices of concern to state regulators:

- Excessive reliance on in-house medical staff to support the denial, termination, or reduction of benefits;
- Unfair evaluation and interpretation of attending physician or independent medical examiner reports;
- Failure to evaluate the totality of the claimant's medical condition; and
- An inappropriate burden placed on claimants to justify eligibility for benefits.

The Unum Multistate Examination Report has been referred to as one of the most significant multistate insurance regulator actions in NAIC history,[7] and it stands as a startling example of what can occur

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[6] *Available at* http://www.secinfo.com/d14D5a.z5UXk.d.htm #1stPage (last visited Mar. 26, 2008).

[7] *See* Multistate Settlement Announcement, quoting then Maine Insurance Superintendent Alessandro Iuppa.

when a rogue insurance company uses ERISA as a shield to protect the nonpayment of legitimate claims. In the course of discovery proceedings against Unum, an internal memorandum written by a Unum executive was uncovered illustrating this point:

> A [company] task force has recently been established to promote the identification of [disability] policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on [company] from having policies covered by ERISA could be significant. As an example, [a company employee] identified 12 claim situations where we settled for $ 7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $ 0.5 million.
>
> In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. **[While] our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.** [Emphasis added]. Mark D. DeBofsky,

Disability Insurance Under the ERISA Law: Economic Security or Litigation Nightmare, 25 J. Ins. Reg. 33, 37-38 (Spring 2007).

Please note that the NAIC is not alleging or implying that Petitioners have been engaged in the same type of inappropriate claim practices as were found against Unum, nor are we making a general statement that these practices are common in the insurance industry. However, Unum's unscrupulous conduct demonstrates the fallacy of Petitioners' argument that market forces are sufficient to deter wrongful claim denial. *See Dishman v. Unum Life Insur. Co. of America,* 1997 WL 906147 10 (C.D. Cal. May 9, 1997), *affirmed in part and denied in part,* 296 F.3d 974 (9th Cir. 2001).

3. WHEN THE ADMINISTRATOR IS THE INSURER ON RISK FOR THE CLAIM, THERE IS AN INHERENT CONFLICT OF INTEREST PRESENT, AND A *DE NOVO* STANDARD OF REVIEW MUST BE USED TO REVIEW THE CLAIM DENIAL.

The second question for which the Court granted certiorari is, as follows: "If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?" *MetLife v. Glenn,* 128 S.Ct. 1117 (2008). Again, the *amicus* brief of the United States filed in this case on writ of certiorari provides an excellent discussion

on the circuit split on the second question presented by this Court. U.S. *Amicus* Br. 9-11.

In adopting the Discretionary Clauses Model Act, which prohibits discretionary clauses in health and disability insurance policies, the NAIC has implicitly recognized that the administrator's decision should be subject to independent *de novo* review, in keeping with the resolution of other insurance disputes.

The Court in *Firestone* recognized that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 103. However, the approaches currently utilized by the circuits do not adequately address the issues that such a conflict raises, such as disability insurance companies using ERISA as a shield to avoid liability, as addressed in the Unum Multistate Examination Report.

The NAIC does not believe that deferential review of claim denials by dual-role companies affords "a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review" as required by ERISA. 29 U.S.C. § 1133(2). A "full and fair review" demands that an aggrieved claimant be allowed to challenge a claim denial in court under a *de novo*[8] standard of review.

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[8] Some cases and commentators have suggested that the standard of review should actually be plenary, and not *de novo*.

(Continued on following page)

NAIC membership is of the view that permitting a group disability insurance policy to intentionally skew the standard of review against the claimant in any way interferes with the protective purpose of insurance regulatory law.

4. THE COURT SHOULD RECONSIDER ITS DECISION THAT ABUSE-OF-DISCRETION REVIEW APPLIES IF "THE BENEFIT PLAN GIVES THE ADMINISTRATOR OR FIDUCIARY DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR BENEFITS OR TO CONSTRUE THE TERMS OF THE PLAN."

Since this Court issued its opinion in *Firestone,* a number of ERISA scholars and commentators have suggested the Court's decision allowing discretionary clauses to be given effect in insurance policies was not based on sound trust law principles or the realities of the insurance marketplace. When the administrator is the insurer on risk for the claim, the Court should reconsider its decision that abuse-of-discretion review applies if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone,* 489 U.S. at 115. The analogy to trust law on which the Court based this portion of its

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See Diaz v. Prudential Ins. Co. of America., 424 F.3d 635, 637 (7th Cir. 2005); and DeBofsky, 25 J. Ins. Reg. at 39.

decision is unsound in these circumstances, and it is contrary to the protective intent of ERISA to allow plan drafters to dictate reduced scrutiny for conflicted plan fiduciaries in contested insurance benefit denial cases.

In *Firestone,* this Court was construing the terms of a self-funded employee benefit plan established by an employer, which was directly responsible for the payment of the plan benefits it had chosen to grant to its employees. *Firestone,* 489 U.S. at 101. In the instant case, by contrast, the employer provided benefits by purchasing an insurance policy, a contract under which a third party insurance company agrees to pay contractually defined benefits. Under this contract, the insurer assumes the risk of profit or loss depending on whether the cost of those benefits turns out to be higher or lower than predicted when pricing the insurance contract. If the insurer pays more claims than anticipated, its remedy is to either raise premiums or limit the scope of coverage for future policy terms, not to exercise discretion and in effect change the rules it has contractually agreed upon for the current term. In these circumstances, the "fiduciary obligation" language of ERISA must be seen as complementing contract law, not replacing it.

Giving the insurer the discretion to interpret its own policy form flies in the face of one of the fundamental principles of insurance law, that any ambiguities that might arise in insurance policies must be resolved so as to honor the reasonable expectations of the insured. This principle arises out of the

common-law doctrine of *contra proferentem* but has been adopted into state law that regulates insurance. *See Leibrand v. Nat'l Farmers Union Prop. and Cas. Co.*, 898 P.2d 1220, 1223 (Mont. 1995) (citing *Bauer Ranch, Inc. v. Mountain West Farm Bureau*, 695 P.2d 1307, 1309 Mont. 1985). State courts have unanimously held that ambiguous policy language must be liberally interpreted in favor of the policyholder and strictly construed against the insurer. 2 Eric Mills Holmes, HOLMES' APPLEMAN ON INS. 2d § 6.1, p. 134 and n. 4 (1996) (citing cases from 37 states).

In *Pilot Life Insurance Co. v. Dedeaux,* 481 U.S. 41 (1987), this Court first held that ERISA preempts state law claims for bad faith breach of an insurance contract and the accompanying punitive damages awards. However, it was not the preclusion of punitive damages alone that led to the current situation, as illustrated by the Unum Multistate Examination Report. The real transformation of insurance claims governed by ERISA occurred after this Court's decision in *Firestone,* which had the effect of conferring a special status on insurers who issue group policies giving them unparalleled authority to determine claims in their discretion. DeBofsky, 25 J. Ins. Reg. at 38.

"In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Massachusetts v. Morash,* 490 U.S. 107, 115 (1989). Through ERISA Congress responded to these dangers by imposing fiduciary standards derived from private

trust law for the administration of all employee benefit pans. In his seminal article on the application of discretionary clauses in disability insurance policies, Prof. Langbein thoroughly analyzes the reliance on trust law in the *Firestone* opinion, and finds it misplaced for a variety of reasons. Langbein, 101 NW. U. L. REV. at 1325-1342. Specifically, he points out dual-role administrators are different from traditional trustees in at least one important way:

> Although "ERISA abounds with the language and terminology of trust law," ERISA fiduciary law differs markedly from conventional trust law in one crucial respect. Trust law presupposes that the trustee who administers a trust will be disinterested, in the sense of having no personal stake in the trust assets, although the trust terms can make contrary provision. By contrast, ERISA fiduciaries are commonly aligned with the employer (or, in most plans that supply insurance benefits, with the insurance company to which the employer delegates administrative responsibilities for the particular plan). *Id.* at 1326.

To the extent that the term "administrator" implies a disinterested third party that is capable of objectively evaluating the merits of a claim, the whole concept of a dual-role administrator is an oxymoron. Insurers are not merely administrators, and it is not realistic to expect them to be disinterested; it is not fair to the insurers to demand that they be disinterested. Instead, it is necessary to adopt both a

regulatory framework and a standard of review that accepts the immutable fact that insurers are interested parties.

This Court has acknowledged that "[b]eyond the threshold statement of responsibility, however, the analogy between ERISA fiduciary and common law trustee becomes problematic. This is so because the trustee at common law characteristically wears only his fiduciary hat when he takes action to affect a beneficiary, whereas the trustee under ERISA may wear different hats." *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000). The flaw in *Firestone*, when applied to insurance companies writing group coverage, is found in this distinction: the common-law trustee is administering a fixed pool of assets, unlike the insurer, which has promised to pay any and all claims under the policy, even if those claims exceed the amount of premiums that were collected.

More importantly, the common-law trust paradigm is based on the expectation that giving the trustee discretionary powers is in the best interest of the beneficiaries as a class, if not specifically in the interest of each individual beneficiary. For example, when a wealthy benefactor endows a trust to provide financial assistance with medical care for family members, each dollar that is spent on one beneficiary is a dollar that is no longer free to spend on another. This is not the case with respect to an insurance policy. Insurance coverage involves no separate trust corpus that requires protection and measured distribution. The payment of benefits

under an insurance policy is a contractual entitlement, not a gratuity.

Therefore, this Court should reconsider the wisdom of the underlying *Firestone* rationale in light of the current realities of claim handling practices in its consideration of the issues before it in this case as applied to fully insured group health and disability income insurance coverage.

CONCLUSION

For the foregoing reasons, the judgment below should be affirmed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

– v. –

WANDA GLENN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION AND OF UNITED POLICYHOLDERS, AS *AMICI CURIAE*, IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE[1]

The National Employment Lawyers Association (NELA) is the largest professional membership organization in the country comprised of lawyers who represent workers in labor, employment and civil rights disputes. NELA advances employee rights and serves lawyers who advocate for equality and justice in the American workplace. NELA and its 68 state and local affiliates have a membership of over 3,000 attorneys who are committed to working on behalf of those who have been illegally treated in the workplace. NELA strives to protect the rights of its members' clients, and regularly supports precedent-setting litigation affecting the rights of individuals in the workplace. Accordingly, NELA has filed amicus briefs to protect the rights of workers and their beneficiaries under the Employee Retirement Income Security Act ("ERISA"). *See, e.g., Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739 (2004); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101 (1989). NELA members have particular expertise in the issues raised in this action not only because they have represented tens of thousands of employees in

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no person or entity other than the *amici curiae*, and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. Written consent to the filing of this brief has been obtained from the parties in accordance with Supreme Court rule 37.3(a). Copies of the consent letters have been filed with the Clerk.

ERISA actions in the lower courts, but also in a number of ERISA cases before this Court. *LaRue v. DeWolff, Boberg & Assoc.*, __U.S. __, 128 S. Ct. 1020 (2008); *Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739 (2004); *Rush Prudential HMO, Inc. v. Moran*, 532 U.S. 141 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); and *UNUM Life Ins. Co. of Amer. v. Ward*, 526 U.S. 358 (1999).

United Policyholders ("UPH") is a single-issue, non-profit organization founded in 1991. The organization's mission is to educate the public, legislators and courts on insurance issues and consumer rights and to help policyholders secure fair, prompt claim settlements. UPH is a recognized charity with tax exempt status under Internal Revenue Code § 501(c)(3), funded by donations and grants from individuals, businesses and foundations. An average of 20,000 monthly visitors read articles and tips at UPH's website, www.unitedpolicyholders.org.

UPH participates in proceedings of the National Association of Insurance Commissioners and receives frequent invitations to speak to trade and civic associations and to testify at public hearings on insurance issues. It also protects the interests and presents the positions of policyholders through participation as *amicus curiae* in insurance cases throughout the country.

UPH's reputation as a reliable friend of the court was enhanced when its *amicus curiae* brief was cited in this Court's opinion in *Humana v. Forsyth*, 525 U.S. 299 (1999), and its arguments were adopted by

the Texas Supreme Court in *Excess Underwriters at Lloyd's, London, et al. v. Frank's Casing Crew & Rental Tools Inc.*, 2008 Tex. LEXIS 92, 51 Tex. Sup. J. (Tex. Feb. 1, 2008), as well as by the California Supreme Court in *Vandenberg v. Superior Court*, 88 Cal. Rptr.2d 366 (Cal. 1999) and in *TRB Investments, Inc. v. Fireman's Fund Ins. Co.*, 145 P.3d 472 (Cal. 2006).

The resolution of the issue in this case is of great importance to both NELA and UPH because of its potential application to millions of employees enrolled in ERISA plans.

SUMMARY OF ARGUMENT

This brief will address only the first question certified for review: "Whether an administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq., is operating under a conflict of interest that must be weighed on judicial review of a benefit determination." *Amici* specifically address Petitioners' contentions that principles of economics dictate that insurers typically will not be impermissibly influenced by their self-interest and, that in any event, considering a conflict of interest would upset contractual expectations.

When employee benefit programs are funded through insurance rather than established through trusts, hard reality shows that insurers left to their own devices will consistently place profits over consumer satisfaction. Even a passing familiarity with

the history of insurance law in the United States underscores that regulation was instituted to protect consumers from the potential for misconduct by insurers. *See* National Association of Insurance Commissioners, "State Insurance Regulation: History, Purpose and Structure," *available at* http://www.naic.org/documents/consumer_state_reg_brief.pdf (visited on March 21, 2008).

Petitioners and their *amici* argue that "business incentives" nullify any instinct of dual-role administrators to act in their own self-interest. *See* Brief of Petitioners at 29-32; Brief of America's Health Insurance Plans as Amicus Curiae at 8-14. However, the real world experiences described below starkly demonstrate how this is not so and, in turn, illustrate how an unchecked arbitrary-and-capricious standard of review has fostered significant mischief and misbehavior. This bias is not deterred by countervailing interests such as the dollar value of an individual claim or an insurer's long-term reputational interests. Moreover, experience has shown that employees can be given incentives, either by offers of rewards or threats of punishment, to behave improperly. Further, the threat of increased costs offers no legitimate justification for insurers to be accorded deference. Finally, given the nature of insurance and the goals and purposes of ERISA, granting deference under principles of freedom of contract is neither supportable nor desirable.

Accordingly, none of Petitioners' economic arguments provide a sufficient rationale to justify unfettered deference to insurers' findings. Hence, this

Court must find MetLife's conflicted role in both administering and paying claims presents a conflict of interest.

ARGUMENT

I. METLIFE ACTED UNDER A CONFLICT OF INTEREST IN ADMINISTERING WANDA GLENN'S CLAIM FOR BENEFITS

The question before the Court as to "[w]hether an administrator that both evaluates and pays [ERISA benefit] claims . . . is operating under a conflict of interest" must be answered in the affirmative, especially with respect to insurance companies with whom employers contract to insure employee benefit plans. While it is no doubt true that insurers must be wary of paying benefits to undeserving claimants, insurers also profit by withholding payments to those who deserve them. The Court need look no further than the text of ERISA to see where the conflict arises. ERISA imposes fiduciary obligations on insurers such as MetLife to act "solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries" 29 U.S.C. § 1104(a)(1)(A)(i). That fiduciary duty is in perpetual conflict, though, with the fiduciary duties MetLife owes its shareholders to return maximal profits. Thus, as the Eleventh Circuit has pointed out,

> when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by

> that company, it is exercising discretion over a situation for which it incurs direct, immediate expense as a result of benefit determinations favorable to plan participants.

Brown v. Blue Cross and Blue Shield of Alabama, Inc., 898 F.2d 1556, 1561 (11th Cir. 1990) (citations omitted). Consequently, neither the financial arguments advanced by Petitioners and their *amici*, nor the reputational interests claimed to act as a sufficient deterrent against misconduct, obviate the plain and palpable conflict of interest under which an insurer operates. Nor are such arguments supported by sound economic principles.

A. There Is an Economic Incentive to Deny Employee Benefit Claims

One of Petitioners' main arguments is that the size of any individual claim is "trivial" when compared with the net assets of the insurer (Brief of Petitioners at 30), thus negating any motivation to wrongfully deny claims. Although the size of an individual benefit claim may pale in comparison to the overall revenues of the company administering benefits, there is irony in the fact that the Circuit that has most frequently advanced that rationale, *see, e.g., Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999), sits in a building named for the political figure who remarked, "A billion here, a billion there, and pretty soon you're talking real money."[2] Inter-

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[2] *See* "Senator McKinley Dirksen Dies,"

nal insurance company documentation as well as several publicized incidents have shown how insurers recognize the aggregate savings that can be gained from rejecting multiple claims. For example, an internal memorandum from a leading disability insurer noted:

> The advantages of ERISA coverage in litigious situations are enormous . . . . [There] are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit[s] in question, and *claims administrators may receive a deferential standard of review.* The economic impact on Provident from having policies covered by ERISA could be significant . . . . *While our objective is to pay all valid claims and deny invalid claims, there are some gray areas, and ERISA applicability may influence our course of action.*

See John H. Langbein, *Trust Law As Regulatory Law: The UNUM/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1321 (2007) (emphasis added). The memorandum further remarked that the insurer "identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million." *Id.*

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http://www.senate.gov/artandhistory/history/minute/ Sentor_Everett_Mckinley_Dirksen_Dies.htm (viewed on February 17, 2008).

It is no secret that UnumProvident and its employees acted on the type of advice contained in the above memorandum in terminating ERISA-governed benefits for scores of its beneficiaries. Petitioners even acknowledge in their Opening Brief (at 37-38) that in 2003 and 2004 Unum entered into regulatory settlement agreements that grew out of a "Targeted Multistate Market Conduct Examination" conducted by 52 participating jurisdictions.[3] The report identified the following areas of concern in its review of UnumProvident's claim practices:

- Excessive reliance upon in-house medical professionals;
- Unfair construction of attending physician or IME reports;
- Failure to evaluate the totality of the claimant's medical condition; and
- Inappropriate burden placed on claimants to justify eligibility for benefits.

As a result of the investigation, Unum was required to reassess more than 200,000 claims that had been denied since January 1, 1997.[4]

That only tells part of the story, though. Testi-

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[3] *See* "Report of the Targeted Multistate Market Conduct Examination," http://maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (viewed on March 21, 2008).

[4] *See id.*

mony and documentary evidence showed:

> UnumProvident has a company-wide practice of denying claims based on UnumProvident's current profits. Claims managers and handlers are given a quota of how many claims need to be "closed," *i.e.* denied, in a given period for the company to remain at a certain level of profitability. Medical advisors such as McSharry are offered bonuses at a level of 25% base pay determined, in part, on company earnings. . . . Claims handlers, his supervisor, and even other doctors employed by UnumProvident pressured McSharry to agree with claims handlers to deny claims. When he did not agree with the claims handlers, his supervisor told him he was not part of the team and he was falling off the career path. . . . Dr. McSharry also testified that there were occasions in which he gave an opinion that the claims handler did not like so the claims handler would ignore his opinion and find another doctor who would provide an opinion more supportive of the claims handler's decision to deny benefits.[5]

The consequences of UnumProvident's behavior show that the value of claim denials was anything

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[5] *Bennett v. Unum*, 321 F. Supp.2d 925, 935 (E.D. Tenn. 2004); *see also Radford Trust v. First Unum Life Ins Co.*, 321 F. Supp.2d 226, 247 n.20 (D. Mass. 2004) (collecting citations to multiple cases that the judge described as "reveal[ing] a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics").

but trivial. UNUM estimated the cost to it of paying the additional benefits after reassessing claims was a sum in excess of $200 million.[6] The empirical evidence thus shows the "triviality" argument carries no weight. There is no actuarial evidence submitted by any of its proponents to support it – only conjecture about financial motivation, which is thoroughly discredited by evidence proving that wrongful denial of individual claims can *and do* add up.

Nor is it correct, as Petitioners have argued, that states' regulation of insurance companies prevents misbehavior (Pet'rs Br. at 37-39). In making that argument, Petitioners have tacitly agreed that misbehavior has occurred and that it enabled UnumProvident to earn significant profits in the aggregate until it was caught and punished. However, as Professor Langbein points out:

> Broadly speaking, there are two plausible interpretations of the Unum/Provident scandal. Unum could be such an outlier that the saga lacks legal policy implications. On this view, a rogue insurance company behaved

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[6] *See* "UnumProvident Announces Settlement of Multistate Market Conduct Examination," *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=112190&p=irol-newsArticle&ID=645732&highlight= (viewed on March 8, 2008); "UnumProvident Reaches Settlement with California Department of Insurance; 'Changing Landscape' May Impact Cost, Availability of Disability Insurance in State," *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=112190&p=irol-newsArticle&ID=763320&highlight= (viewed on March 8, 2008) (describing charges taken by UnumProvident to fund the Regulatory Settlement Agreement and California Settlement Agreement).

> exceptionally badly, it got caught and was sanctioned, and its fate should deter others. The other reading of these events is less sanguine: For reasons discussed below in Part III, conflicted plan decisionmaking is a structural feature of ERISA plan administration. The danger pervades the ERISA-plan world that a self-interested plan decisionmaker will take advantage of its license under *[Firestone Tire v.] Bruch* to line its own pockets by denying meritorious claims. Cases of abusive benefit denials involving other disability insurers abound. Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect.

Langbein, *supra*, at 1321; *see also Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 511 F.3d 1206 (9th Cir. 2008).

Petitioners have not presented the Court with any empirical evidence that the UnumProvident Settlement Agreements have changed anything. The Court of Appeals below observed that MetLife was engaging in precisely the same misbehavior that was described in the Multistate Examination. Thus, MetLife's own conduct belies the argument that insurance companies won't bother wrongfully denying the small claim.

Focusing on the individual claim therefore entirely misses the point. The UnumProvident example starkly demonstrates that profit motive is powerful –

there is a large profit to be gained from aggregating a substantial number of small claim denials. Thus, the UnumProvident situation offers a concrete example refuting the broad assertions of MetLife that insurance companies with high revenues and significant assets are above influence.

MetLife would have this Court believe that the UnumProvident experience had its intended effect on the insurance industry and this Court need not worry that the profit motive will further interfere with objective decision-making. Unfortunately, events have proven otherwise. For example, in January 2008, the California Department of Insurance fined UnitedHealth Group, Inc. (PacifiCare) $30 million for violations of state insurance laws. UnitedHealth is the nation's biggest provider of health care insurance. The Commissioner is also seeking to impose penalties of another $1.33 billion for 133,000 additional violations of law. The Commissioner conducted an audit of UnitedHealth's claims practices and concluded that fully 30% of all claims had been wrongfully denied – a total of 133,000 claims. This audit was conducted in June 2007, well after the UnumProvident settlement in 2004.[7]

A wrongful denial rate of thirty percent cannot be ascribed to anything other than a system-wide failure. The investigation did not reveal any correlation between the size of the claim and whether it would be wrongfully denied, but it did describe failures in

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[7] *See* California Department of Insurance R*eport. available at* http://www.dmhc.ca.gov/library/reports/hp_exam/exams/126nonroutinc011608.pdf (visited February 26, 2008).

how claims were processed and how evidence was viewed.

Another example occurred in February 2008, when New York's Attorney General announced its own industry-wide investigation based on its findings that UnitedHealth Group, Inc., created a "convoluted and dishonest system" for reimbursing for out-of-network services.[8]

The list goes on:

- In December, 2004, United Healthcare agreed to pay the federal government $3.5 million to settle allegations the company defrauded the Medicare program.[9]

- Health Net, another major player in the health insurance market, faces problems of its own. Making the headlines recently was a $9 million arbitration verdict after a finding of wrongful cancellation of Patsy Bates's health insurance.[10] Based on the

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[8] *See* "Cuomo Announces Industry-wide Investigation into Health Insurers' Fraudulent Reimbursement Scheme," *available at* http://www.oag.state.ny.us/press/2008/feb/feb13a_08.html (viewed on February 26, 2008).

[9] *See* "United Healthcare Insurance Agrees to Pay U.S. $3.5 million to Settle Fraud Charges," *available at* http://www.usdoj.gov/opa/pr/2004/December/04_civ_788.htm (viewed on March 28, 2008).

[10] *See* "Health Net ordered to pay $9 million after canceling cancer patient's policy," *available at* http://www.latimes.com/features/health/la-fi-insure23feb23,1,2680255.story; *see also* "Health insurer tied

> evidence presented at trial, Retired Judge Cianchetti concluded that the persons in charge of policy rescissions were given concrete rescission goals and were paid bonuses based on whether they achieved those goals. The employee who terminated Ms. Bates's policy was described by her supervisor as having had a "banner year" for exceeding her goals in the number of rescissions and the amount saved by the company because of the rescissions ($6 million).[11]

In yet another example of improper financial motivations affecting a disability insurer administering ERISA benefits, *Wilkerson v. Riffage.Com*, Case No. CV 03-4926 RMW (N.D. Cal.), *available at* PACER, Document 61, Part 3, Exhibit A, revealed how Sun Life maintained a "white board" in the claims department showing how the claims staff were meeting their "goals." One such goal was to meet an anticipated number of benefit denials and terminations. To encourage his employees to meet the stated "goals," a manager sent a memo to his staff urging them to produce more denials and terminations (pp. 590-591) so that the month's goals could be met. It worked. Before the memo went out, his staff were producing an average of five denials or terminations a day. After the memo was issued, terminations increased to an average of sixteen per day (p. 595). In

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bonuses to dropping sick policyholders," *available at* http://www.latimes.com/business/la-fi-insure9nov09,1,5093427.story.

[11] *In the Matter of Arbitration between Bates v. Health Net*, Case No. BC321432 (Feb. 21, 2001) (Cianchetti, J., Ret.), *available at* http://uniset.ca/other/cs5/healthnet_arbitr.html.

June of that year, when projected profits were down by $1 million for the month, the Manager of Claims issued a memo offering cash prizes for denials. For each denial of a claim performed on a weekday, a claims person would receive three chances to win a cash prize. If additional motivation was shown and a termination was processed on a weekend, the chance of winning the prize was doubled. The prize? Two-hundred and fifty dollars. Although the Vice President of claims called a halt to the raffle, he expressed no objection to encouraging claims people to generate more denials in order to meet goals (p. 582).

In each of these cases, the structure of the claims department, the motivations given to employees and the work product that resulted shows that denials were encouraged, promoted, and praised irrespective of the value of each claim. In each of these examples, either a whistleblower or simply pure happenstance allowed an outsider a glimpse into an insurer's workings. Thus, Petitioners' triviality argument must fail when the hard reality shows that insurers' prevailing custom is to focus on aggregate savings which, as demonstrated above, can ultimately be quite significant.

B. Reputational Incentives Are Not a Sufficient Basis to Ignore Insurers' Conflicts of Interest

Petitioners and their *amici* place great weight on insurers' reputational interest as a safeguard against conflicts of interest (Brief of Petitioners at 29-30). However, as pointed out by the Third Circuit

in *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000), these interests are hardly sufficient to prevent misbehavior:

> To amplify, while in a perfect world, employees might pressure their companies to switch from self-dealing insurers, there are likely to be problems of imperfect information and information flow. Employees typically do not have access to information about claim-denying by insurance companies, and the relationship between employees and insurance companies is quite attenuated; so long as obviously meritorious claims are well-handled, it is unlikely that an insurance company's business will suffer because of its client's employees' dissatisfaction. Additionally, many claims for benefits are made after individuals have left active employment and are seeking pension or disability benefits. Details about the handling of those claims, whether responsible or irresponsible, are unlikely to seep into the collective knowledge of the still-active employees.

Mers, 144 F.3d at 1020.

Without a doubt, all businesses would prefer to enjoy a good reputation. However, the counter-incentives of achieving significant profits or savings often provide an even stronger motive. For example, in *Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996), a case in which $125 million was at stake dependent on how employees' pensions were calcu-

lated, the Seventh Circuit acknowledged, "a loss of reputation might be a price worth paying to avoid $125 million in unanticipated expense." Of course, $125 million can also be a "price worth paying" when aggregated across many cases involving "small" claims. And in a pre-*Firestone* case, *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987), the Seventh Circuit aptly remarked that employee benefits "are too important these days for most employees to want to place them at the mercy of a biased tribunal subject only to a narrow form of 'arbitrary and capricious' review, relying on the company's interest in its reputation to prevent it from acting on its bias." 836 F.2d at 1052.

Empirical evidence further undermines Petitioners' theoretical argument. If reputational injury were indeed a factor, insurers could expect to see their stock prices quickly decline and revenues plummet in the face of reputation-damaging news. UnumProvident's experience shows just the opposite, however. The Targeted Multistate Market Conduct Examination was made public on November 18, 2004. On November 12 of that year, Unum's stock was selling at $13.45 per share. The day after the report, Unum's stock was up to $15.35 per share; and Unum's share price has continued to climb. In May 2007 it reached a high of $27.57 and currently sells around $23 per share. Unum has not missed paying its regular dividend since the Multistate report.[12]

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[12] *See* Unum "Stock Dividend & Split History," *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=112190&p=irol-dividends.

Further, according to UnumProvident's most recent SEC Form 10-K filing, from 2004 through 2007, revenues have remained flat, benefit payments have declined, and 2007's "net income" was just short of $1 billion greater than it was is 2004.[13] UnumProvident's website trumpets that it remains the number one seller of both group and individual disability insurance, further undermining the assertion that news affecting reputation has an effect.[14] Despite the charges taken against earnings, the scandal surrounding Unum's conduct has not affected its reputation – or at least its bottom line. Profits have soared. If anything, the Unum situation offers the wrong lesson for the insurance industry.

According to United Healthcare's 10K filing for the year ending December 31, 2007, while performing slightly less well than their "peer group," for the last five years it has substantially outperformed both the S&P 500 and the Fortune 50.[15] Like UnumProvident, United Health Group's stock is clearly not suffering from the reports of the New York and California investigations.

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[13] *See* "10-K Annual Report" (Feb. 25, 2008), *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=112190&p=irol-sec&secCat01.1_rs=11&secCat01.1_rc=10.

[14] *See* Unum "Our Corporation," *available at* http://www.unum.com/aboutus/whoweare.aspx (viewed on March 28, 2008).

[15] *See* UnitedHealth Group "Annual Report on Form 10-K for period ended December 31, 2007," at 17-18, *available at* http://www.unitedhealthgroup.com/invest/2007/10-K_2007.pdf (viewed on March 28, 2008).

In a survey published this month asking hospital executives to rate various health insurers, United Healthcare came in last, with 91% of the executives giving United Healthcare an unfavorable rating. United Healthcare's atrocious reputation has done nothing to affect its domination of the industry or its bottom line profits.[16]

Thus, in law-and-economics terms, there is no well-functioning market that distributes information to prospective employees about the "reputation for fair dealing" of particular insurers. This market distortion results in a severe information asymmetry. As such, prospective employees will—absent unique circumstances—simply look at the type, level, amount, and cost (if any) of benefits offered by a potential employer, and not insurers' claim rejection rates. For instance, an employee might consider whether a plan is an HMO versus PPO or what the level of co-payments and deductibles are. But whether one employer's insurer versus another employer's insurer has a better track record for granting claims is simply not a piece of information that is readily available—other than perhaps from scattered hearsay—for a prospective employee to take into account.

Nor is the marketplace as robust as Petitioners and their *amici* claim. A recent article pointed out that the top ten disability insurers control 83% of the

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[16] *See* 2008 National Payor Survey, "Payor Image and Reputation," at 9, *available at* http://www.daviespublicaffairs.com/downloads/Payor_Survey_Results_Web.pdf (viewed on March 28, 2008).

market share.[17] And even the strongest proponents of the "reputational interest" argument have come to question its underpinnings. The First Circuit, in *Denmark v. Liberty Life Assur. Co.*, 481 F.3d 16, 30 (1st Cir. 2007), has questioned its prior jurisprudence; and even the Seventh Circuit acknowledged in *Rud v. Liberty Life Assur. Co.*, 438 F.3d 772, 776 (7th Cir. 2006), that its earlier rulings may "reflect[ ] too sunny a view of the operation of labor markets." Without any empirical or actuarial evidence from Petitioners, this Court cannot accept theory and conjecture when it has been shown that an interest in a good reputation has hardly proven to be a deterrent against misbehavior.

C. Employee Incentives Promote Conflicted Behavior

Petitioners and their *amici* argue that it is difficult to incentivize employees to participate in wrongful denials of claims (Petitioners' Brief at 31-32). However, the cases and situations cited above suggest that when employees are offered rewards or threatened with punishment, they become highly motivated to deny even meritorious claims.

In addition to these cases, the Eighth Circuit found that "[a]pparently to limit claim payments, Aetna provides incentives and bonuses to its claims reviewers based on criteria that include a category

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[17] *See* "2008 Group Disability Insurers," *available at* http://www.workforce.com/section/02/feature/25/37/29/index.html (viewed on March 15, 2008).

called 'claims savings,'" in other words, the total value of claims denied. *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997). Taken together—the bonuses in *Armstrong*, the testimony and documentation in *Bennett* on how Unum motivated its employees, Health Net's measuring employee performance by how many policies the employee rescinds (including characterizing an employee who exceeded her goal as having a "banner year"), and the raffle disclosed in *Wilkerson*—it is plainly evident that insurers structure their work environments so that claim decisions are not made by unbiased individuals.

Rather, the only tangible evidence the public has glimpsed involve employees who are highly motivated either by potential rewards for saving their employers' money or who are threatened with punishment if they fail to deny enough claims. Thus, there is ample evidence that insurers have actively worked to give their employees incentives to close or deny claims. In each of the situations recounted above, the insurance companies had absolutely no problem in motivating its employees to quickly fall into step. All it took was for the supervisor to provide direction and to give praise when goals were met.

Theoretical and unsubstantiated beliefs about how corporations behave, and how corporate employees act, should not be sufficient to outweigh the real life evidence to the contrary. Accordingly, as Professor Langbein concludes:

> [T]he view advanced in the Seventh Circuit – that "applying a law-and-economics rationale . . . establishes that no conflict exists" in benefit denial cases involving conflicted decisionmakers – is bad law and bad economics.

Langbein, *supra*, at 1331.

D. The Threat of Increased Costs Is Not a Basis for Maintaining Undiminished Deference

Amici for Petitioner argue that recognition of a conflict when insurers both administer claims and pay benefits would increase the cost of litigation. *See* Brief of Petitioners at 28; Brief of America's Health Insurance Plans as Amicus Curiae at 19. That argument was already rejected by this Court in *Firestone* when it made it clear that "the threat of increased litigation is not sufficient to outweigh the reasons for a *de novo* standard that we have already explained." 489 U.S. at 115.

That holding rested on this Court's sound recognition that ERISA's primary goal is "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits," 489 U.S. at 113 (citations and internal quotation marks omitted), and that to do otherwise "would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted," *id.* at 114 (emphasis added).

In any event, there is no dispute that recognition

the added protection for employees. *See* 1 ERISA Leg. History 604 ("it is intended that coverage . . . be construed liberally *to provide the maximum degree of protection* to working men and women covered by private retirement programs") (emphasis added), *quoted in* Jorden at al., *supra*, at 1-8 n.11. And for good reason. It is unimaginable that employees would trade-in a truly "full and fair" neutral court proceeding to save a few percentage points on costs, just as no one would choose to fly on a substantially more accident-prone airline or undergo a major medical procedure at a hospital with a significantly higher mortality rate simply to save a few cents on the dollar. This is especially so because disputes over welfare benefits often occur in times of serious illness or disability—the very moment when the ability to challenge a benefit denial in a court proceeding that affords no deference to the insurer, even if somewhat more expensive, would be a small price to pay.

In sum, employee benefits are too important to entrust payment decisions to insurers that can decide in their unfettered discretion when payments are due. Our court system would not trust insurers in any other context to make decisions reviewable only for arbitrariness; even more so, no legitimate rationale supports giving undiminished authority to insurers in the protective ERISA context. As this Court rightly recognized in *Firestone*, the cost savings argument cannot override ERISA's language, legislative history, and judicial precedent.

of a conflict of interest would *not* significantly increase insurance costs. In a study commissioned by America's Health Insurance Plan ("AHIP"), two consulting actuaries predicted that entirely eliminating discretionary clauses in ERISA-governed plans and *instituting full "de novo" review with a jury trial* would increase disability insurance premiums *by only 3-4%.*[18] Of course, there are no jury trials in ERISA claims for benefits. *See* James F. Jorden at al., HANDBOOK ON ERISA LITIGATION (3d ed. 2006), at 4-164. Moreover, the actuaries estimated increased costs based on the "average cost to litigate individual" disability claims,[19] which not only include jury trials, but typically punitive damages, which are also not available in ERISA actions. *See* Eugene Anderson et al., INSURANCE COVERAGE LITIGATION (2000), at 8-4; Jorden at al., *supra*, at 4-150. Thus, the 3-4% figure is a gross over-estimate of increased costs. As such, is not surprising that AHIP ignored its own study in its amicus brief filed in this case, instead arguing that a "*de novo* standard" would "drive up costs," but notably failing to specify by how much. Brief of AHIP, at 19.

When Congress decided "to protect" employees' "contractually defined benefits" with the strict duty of loyalty from trust law and a prohibition of exculpatory clauses in benefit plans, it made a considered choice that raising insurance costs was well worth

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[18] See "Impact of Disability Insurance Policy Mandates Proposed by the California Department of Insurance," at 8, *available at* http://www.ahip.org/content/default.aspx?docid=13557 (viewed on March 29, 2008) (emphasis added).

[19] *See id.* at 9.

E. Undiminished Deference is Not Justified by Principles of Freedom of Contract

Finally, there is no reason to find that principles of freedom of contract compel an undiminished abuse of discretion review of insurers' findings. Such an argument would contravene the regulatory purpose behind ERISA. As noted earlier, Congress' motivation in enacting ERISA was to intervene in order to prevent unfettered contractual freedom from harming employee benefit plan participants. Thus, the law incorporates a strict and protective duty of loyalty for plan administrators as well as a provision that makes it unlawful to include exculpatory clauses in employee benefit plans. 29 U.S.C. § 1110(a). Indeed, when *Firestone* was before the Court, the Solicitor General argued that the prohibition of exculpatory clauses in ERISA means the "language in a plan document purporting to give biased administrators unbounded discretion to decide what the terms of the plan mean . . . would not be enforceable under ERISA." Brief for the United States as Amicus Curiae Supporting Respondents, 1987 U.S. Briefs 1054 (LEXIS) at 27 n.11.

Further criticism of Petitioners' freedom of contract argument comes from academic quarters. In his recent essay, Professor John Langbein points out:

> In resorting to the language of contract to justify the self-serving behavior of an ERISA plan administrator who decides benefit claims, Judge Posner overlooks a profoundly

> important difference: ERISA requires the administrator (or an insurer exercising delegated powers of plan administration) to act in a fiduciary capacity. Under ERISA's duty of loyalty, the decisionmaker must interpret and apply plan terms "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . ." [29 U.S.C. § 1104(a)(1).] Judge Posner is, therefore, confusing a contract counterparty, who is allowed to act selfishly, with an ERISA fiduciary, who is forbidden to.

Langbein, *supra*, at 1329-30.

ERISA imposes other substantial restraints on freedom of contract. Its inclusion of rules prohibiting self-dealing and kickbacks (29 U.S.C. §§ 1106-1108) make Congress' intent to place limits on freedom of contract clear. Moreover, the principle of ERISA as regulatory law has been well-accepted, as illustrated by *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048 (7th Cir. 1987), where Judge Posner (before adopting his "freedom of contract" stance rejected by Professor Langbein above) noted:

> Nor is it clear that the contractual perspective is the correct one in which to view claims under ERISA. A Congress committed to the principles of freedom of contract would not have enacted a statute that interferes with

> pension arrangements voluntarily agreed on by employers and employees. ERISA is paternalistic; and it seems incongruous therefore to deny disappointed pension claimants a meaningful degree of judicial review on the theory that they might be said to have implicitly waived it.

Id. at 1052.

Again, Petitioners' argument fails to take into consideration that a primary goal of ERISA is "to protect contractually defined benefits," *Massachusetts Mutual v. Russell*, 473 U.S. 134, 148 (1985). Once plan terms governing the provision of benefits are contractually established, ERISA relies on stricter trust law principles to protect these "contractually defined benefits." *Post v. Hartford Ins. Co.*, 501 F.3d 154, 163 (3rd Cir. 2007). *Cf. Original Great American Chocolate Chip Cookie Co. v. River Valley Cookies, Ltd.*, 970 F.2d 273, 280 (7th Cir. 1992) (Posner, J.) ("Contract law . . . does not proceed on the philosophy that I am my brother's keeper. That philosophy may animate the law of fiduciary obligations but parties to a contract are not each other's fiduciaries."). Accordingly, freedom of contract is not a justification for ignoring the conflict of interest under which administrators of unfunded benefit plans operate.

CONCLUSION

The current regime of ERISA benefit adjudication under the arbitrary and capricious standard of review consists of no more than a lenient "administrative" review without any opportunity for trial proceedings or even the taking of discovery absent a preliminary showing that an actual conflict infected the claim determination. *See, e.g., Semien v. Life Insurance Co. of North America,* 436 F.3d 805 (7th Cir.); *cert. denied* 127 S. Ct. 53 (2006). That manner of adjudication, coupled with the limited remedies available under ERISA, enhances the danger of conflicted plan administrators' misbehavior.

There is nothing in the record to support Petitioners' argument that insurance companies are sufficiently enlightened that they would not sacrifice long-term reputational interests for short-term profits. All the empirical evidence proves the contrary is true. While a particular case might be considered to have but "trivial" value, hundreds or thousands of such cases denied with impunity under the abuse of discretion standard undoubtedly can be highly profitable – in UnumProvident's case, at least $200 million in extra profits.

Nor have the scandals cited above resulted in any deficit to the insurers' reputations or modification of aberrant behavior. The evidence also shows that employees are more than willing to follow the instructions of their supervisors. The Sun Life example demonstrates this in bold relief. When their supervisor called for "25 more terms" in a day and a

half, the claims examiners complied, tripling their daily average of denials and terminations. These facts belie a statistical fluke as the cause of the spike in denials; the cases cited by amici show a pattern of employees receiving either punishment for not going along with unjustified claim denial (*Bennett*) or reward for those who do (*Wilkerson, Bates, Armstrong*). Thus, the dual-role conflict is palpable. In *Brown v. Blue Cross & Blue Shield*, the Eleventh Circuit appropriately noted, "A conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." 898 F.2d at 1565. That observation is the one reflecting reality; to ignore such motivations is to deprive plan participants of deserved benefits.

Accordingly, when the insurer of employee benefits both determines the eligibility to receive benefits and is responsible for paying the benefits out of its own funds, a conflict exists that must be factored into the deference, if any, to be accorded the benefit claim determination.

For these reasons, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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IN THE
Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,
Petitioners,

v.

WANDA GLENN,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE NEW YORK CITY CHAPTER OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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The New York Chapter of the National Multiple Sclerosis Society respectfully submits this brief as *amicus curiae* in support of respondent, with the written consent of the parties.[1]

INTERESTS OF *AMICUS CURIAE*

The New York City Chapter of the National Multiple Sclerosis Society serves the thousands of New Yorkers living with Multiple Sclerosis ("MS") and their families by providing comprehensive support services and educational programs and by funding a national research initiative seeking the cause, treatments and cure for this chronic neurological disease. There are more than 7,000 families in New York City and 400,000 in the United States affected by MS. New York is one of nine states with the highest incidence of MS in the nation.

MS is a chronic, often disabling, disease that attacks the central nervous system, which is made up of the brain, spinal cord and optic nerves. MS can cause blurred vision, loss of balance, poor coordination, slurred speech, tremors, numbness, extreme fatigue, problems with memory and concentration, paralysis, blindness and more. These

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[1] Letters of consent have been filed with the Clerk. No party or counsel for a party to this case authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity other than *amicus curiae*, its members or its counsel has made a monetary contribution to the preparation or submission of this brief.

problems may be permanent or may come and go. The progress, severity and specific symptoms of MS are unpredictable and vary from one person to another.

Thousands of the families affected by MS in New York rely on health and disability insurance benefits provided through employee welfare benefit plans regulated under ERISA. The ability of these families to continue to rely on these benefits is of vital importance. An improper denial of benefits by a conflicted insurance company could mean that an MS patient must forego medically necessary care or be unable to afford even the most basic living expenses.

INTRODUCTION AND SUMMARY

I. Article III of the Constitution grants a federal litigant asserting a "private right" the constitutional right to "an impartial and independent federal adjudication of claims." Consequently, Courts can address the irreconcilable conflict of interest in "ERISA Insurance Cases"[2] only by providing a plenary *de novo* proceeding. To do less, by deferring to the determination of a conflicted insurance company, constitutes an unconstitutional relegation of judicial power to a conflicted insurance company.

II. There is no authority in this Court's constitutional precedent, ERISA or *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), for

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[2] "ERISA Insurance Cases" means a case involving a fully-insured welfare benefit plan governed under ERISA.

denying Mrs. Glenn her constitutional right to an impartial and independent federal adjudication under Article III.

A. Relegation of judicial power to MetLife is constitutionally impermissible. Although this Court has recognized two very narrow exceptions to unfettered Article III adjudication of private rights, neither is applicable to ERISA Insurance Cases. First, a claim for long term disability benefits is a purely "private right," and Congress did not create an Article I Court or tribunal to decide ERISA employee benefit disputes. *See, Thomas v. Union Carbide Agricultural Products Co.*, 473 U.S. 568 (1985). Second, Mrs. Glenn never waived her right to Article III adjudication. *See, Commodity Futures Trading Commission v. Schor*, 478 U.S. 833 (1986). Nor was there a constructive waiver when Mrs. Glenn's employer, Sears, Roebuck and Company, agreed to grant discretionary authority to MetLife in the long term disability plan. Constructive waivers of fundamental constitutional rights are not permissible. *See, e.g., College Sav. Bank v. Fla. Prepaid Post-secondary Ed. Expense Bd.*, 527 U.S. 666, 682 (1999).

B. Relegation is not authorized under the text of ERISA or by its legislative history. ERISA specifically authorizes participants to commence "civil actions" subject to the jurisdiction of the federal courts. *See, e.g.*, 29 U.S.C. §§1001(b), 1132(a)(1)(B), 1132(f). Early drafts of ERISA considered relegating judicial power to an Article I tribunal, *i.e.*, a grievance or arbitration proceeding

before the Secretary of Labor to resolve disputes. *See* S. Report 93-383, *reprinted in*, 1974 U.S.C.C.A.N. 4890, 4999-5000. The final bill, however, did not contain either of these proposals. The fact that Congress considered and then purposefully rejected an Article I tribunal is conclusive proof that Congress did not intend to limit the Article III rights of claimants. Because ERISA is a comprehensive and reticulated statute, Courts should be reluctant to tamper with its enforcement scheme. *See, e.g., Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 217-218 (2002).

C. Relegation is not authorized by *Firestone*. *Firestone* never considered the applicability of Article III. *Firestone* also did not evaluate or consider the significant differences between a fully-insured welfare benefit plan and a fully-funded or unfunded trust. Indeed, *Firestone* specified that its holding applied regardless of whether a plan was "funded or unfunded," but did not specify that it applied to insured plans. 489 U.S. 101 at 109. There are good reasons for treating insured plans differently from funded or unfunded plans. *Firestone* recognized the imperative of not applying a standard of review that "would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." 489 U.S. 101 at 104. But, that is precisely what would happen if deference were granted to conflicted insurance companies. Under traditional insurance law, ambiguities in insurance policies are interpreted <u>against</u> the insurance company under the doctrine of *contra proferentem*, not in their favor

as would happen under a deferential standard of review. 2D Holmes's Appleman on Insurance, §6.1 (1996).

ARGUMENT

I. ARTICLE III OF THE CONSTITUTION REQUIRES A *DE NOVO* PLENARY PROCEEDING WHEN AN ERISA INSURANCE CASE IS DEFENDED BY A CONFLICTED INSURANCE COMPANY

Mrs. Glenn has a constitutional right to have her "private right"[3] to long term disability benefits adjudicated under the "judicial power" of an Article III Court. To protect her constitutional right, a *de novo* plenary proceeding is required. Granting any level of deference to MetLife, a conflicted insurance company, would be a constitutionally impermissible relegation of judicial power.

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[3] *See Murray's Lessee v. Hoboken Land & Improvement Co.*, 59 U.S. (18 How.) 272, 284, 15 L.Ed. 372, 377-378 (1855) (Distinguishing between "private right" requiring Article III adjudication and the exception for "public rights" which may be resolved by administrative agencies or Article I Courts); Richard H. Fallon, *Of Legislative Courts, Administrative Agencies and Article III*, 101 Harv. L. Rev. 916 (1988) (concluding that meaningful judicial review in an Article III court is a necessary and sufficient requirement under the Constitution).

A. The Constitution Requires the Adjudication of "Private Rights" By An Unfettered Article III Court

Article III of the Constitution not only serves as an inseparable element of the constitutional system of checks and balances, but it also confers a personal right on litigants to have an Article III judge preside over a civil trial. *Peretz v. United States*, 501 U.S. 923, 936 (1991). Article III "preserves to litigants their interest in an impartial and independent federal adjudication of claims within the judicial power of the United States." *Schor*, 478 U.S. 833 at 850.

This Court has held that Article III restricts Congress from relegating adjudicative functions to non-Article III courts and tribunals when the dispute is over "private" rather than "public" rights. *See, Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33, 52 (1989):

> Our prior cases support administrative factfinding in only those situations involving "public rights," e.g., where the Government is involved in its sovereign capacity under an otherwise valid statute creating enforceable public rights. Wholly private tort, contract, and property cases, as well as a vast range of other cases, are not at all implicated.[4]

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[4] In his concurring opinion, Justice Scalia indicated that he would hold that public rights are only those affecting the government. All other rights are private rights. Justice Scalia

. . .

> ...if a statutory cause of action,...is not a "public right" for Article III purposes, then Congress may not assign its adjudication to a specialized non-Article III court lacking the essential attributes of the judicial power.

Thus, "private rights" must be decided by an impartial and independent Article III court. This means an independent adjudication without deference to one of the parties to that very litigation.

B. ERISA Insurance Benefits Are "Private Rights" Requiring Article III Adjudication

A claim for long term disability benefits from a private insurance company is a quintessential "private right." Prior to the enactment of ERISA, employer-provided long term disability insurance claims were adjudicated under state insurance law. When Congress passed ERISA, however, it effectively "federalized" all private sector employee benefits, including long term disability benefits. In so doing, 29 U.S.C. §1132(a)(1)(B) displaced traditional State causes of action under State

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indicated that he departed with the exceptions described in *Thomas* and *Schor*:

> The notion that the power to adjudicate a legal controversy between two private parties may be assigned to a non-Article III, yet federal, tribunal is entirely inconsistent with the origins of the public rights doctrine. The language of Article III itself, of course, admits of no exceptions. . .

492 U.S. 33 at 66.

insurance laws.[5] *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987)(holding state common law causes of action arising from the improper processing of a claim are preempted under ERISA).

Because Mrs. Glenn's litigation against MetLife arises from a private property dispute that, prior to the passage of ERISA, was historically resolved under State laws, her claim is one that requires Article III resolution. *See, Thomas, 473 U.S.* 568 at 587 ("Most importantly, the statute in *Crowell* displaced a traditional cause of action and affected a pre-existing relationship based on a common-law contract for hire. Thus it clearly fell within the range of matters reserved to Article III courts . . . ").

II. RELEGATION OF JUDICIAL POWER, IN THE FORM OF DEFERENCE TO A CONFLICTED INSURANCE COMPANY, IS CONSTITUTIONALLY IMPERMISSIBLE

There is no authority in this Court's constitutional precedents, ERISA or *Firestone* for denying Mrs. Glenn her constitutional right to an impartial and independent federal adjudication under Article III.

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[5] State insurance law is not entirely pre-empted. 29 U.S.C. §1144(b)(1) saves certain insurance law from federal preemption in connection with fully-insured ERISA plans.

A. The Two Limited Exceptions Specified In *Thomas* And *Schor* Do Not Authorize The Relegation Of Judicial Power To A Conflicted Insurance Company

There are only two limited instances in which Congress is authorized to relegate adjudicative authority of "private rights" for resolution by a non-Article III court or tribunal. *See, Thomas*, 478 U.S. 568 (1985); *Schor*, 478 U.S. 833 (1986). In enacting ERISA, Congress invoked neither.

In *Thomas*, this Court permitted an Article I arbitration adjudication, subject to judicial review only for fraud, misrepresentation, or other misconduct, because: (1) the right created by the Federal Insecticide, Fungicide, and Rodenticide Act as to the use of a registrant's data was not a purely "private" right, but bore many of the characteristics of a "public" right; (2) the arbitration scheme was necessary as a pragmatic solution to the difficult problem of spreading the costs of generating adequate information regarding the safety, health and environmental impact of a potentially dangerous product; and (3) the scheme contained its own sanctions and subjected no unwilling defendant to judicial enforcement power. Given the nature of the right at issue and the concerns motivating Congress, this Court held that the Article I adjudication did not violate Article III. 473 U.S. 568 at 590.

On its face, the *Thomas* exception is inapplicable to ERISA Insurance Cases because Congress did not even create an Article I Court or tribunal (including

a private insurance company) to decide employee benefit disputes arising under ERISA. *See, e.g., Downs v. Liberty Life Ass. Co. of Boston*, 2005 U.S. Dist. LEXIS 22531, *19 (N.D. Tex. 2005)(". . . Congress did not delegate any adjudicative authority to employers or plan administrators when enacting ERISA . . ."); *Black v. UNUMProvident Corp.*, 245 F.Supp.2d 194, 199 (D.Me. 2003)("ERISA does not delegate any adjudicative functions to an otherwise private party."). Thus, there is no *Thomas*-like relegation to an administrative agency or legislative Article I tribunal.

In *Schor*, this Court held that "Article III's guarantee of an impartial and independent federal adjudication is subject to waiver, just as are other personal constitutional rights that dictate the procedures by which civil and criminal matters must be tried." *Schor*, 478 U.S. 833 at 848-849. The *Schor* waiver exception, however, cannot justify deference to a conflicted insurance company because: (1) Congress did not establish a method under which a claimant could waive her Article III rights; and (2) there has been no voluntary, knowing and intelligent waiver by Mrs. Glenn.

First, in *Schor*, Congress specifically established an Article I tribunal under which a claimant could voluntarily assert a claim. 478 U.S. 833 at 855 ("Congress gave the CFTC the authority to adjudicate such matters, but the decision to invoke this forum is left entirely to the parties . . ."). ERISA is different. As argued, *supra*, neither the ERISA statute, nor its legislative history, contains any

language establishing an Article I tribunal at the Department of Labor or otherwise. Moreover, the ERISA statute does not contain any language establishing a waiver scheme under which a claimant may voluntarily waive her right to an Article III proceeding in favor of a deferential review.

Second, in *Schor*, there was no dispute that the plaintiff voluntarily waived her right to Article III adjudication by voluntarily filing a counterclaim before the CFTC. Here, no argument can be made that Mrs. Glenn meaningfully waived her Article III rights. Constitutional rights cannot be waived haphazardly, but, rather, only in a voluntarily, knowing and intelligent manner. *See, e.g., Adams v. United States ex rel. McCann,* 317 U.S. 269 (1942) (waiver of right to jury trial). "Courts indulge every reasonable presumption against waiver of fundamental constitutional rights." *See, e.g., College Sav. Bank*, 527 U.S. 666 at 682.

A waiver cannot be inferred by the mere fact that Mrs. Glenn voluntarily enrolled as a plan participant under the MetLife insurance policy or commenced a lawsuit in federal court. There is no evidence that Mrs. Glenn was provided an opportunity to elect coverage subject to a *de novo* proceeding versus coverage where MetLife's determination would be granted deference. Nor was she provided with a document explaining her constitutional rights afforded under Article III and what the consequence of waiving those rights might be.

Moreover, the fact that Mrs. Glenn's employer might have voluntarily agreed to the inclusion of discretionary language in the plan document of the long term disability plan is insufficient to constitute a meaningful constitutional waiver on the part of Mrs. Glenn. A third-party "constructive waiver" by Mrs. Glenn's employer is far afield from the undisputed waiver in *Schor* and the meaningful waiver required of *Adams,* 317 U.S. 269 at 272-273. As this Court stated in *College Sav. Bank*:

> We think that the constructive-waiver experiment of *Parden* was ill conceived . . .
>
> . . .
>
> Indeed, *Parden*-style waivers are simply unheard of in the context of *other* constitutionally protected privileges. As we said in *Edelman*, "constructive consent is not a doctrine commonly associated with the surrender of constitutional rights."

527 U.S. 666 at 680, 682 (citation omitted).

Thus, this Court has clearly enunciated that waiver of a constitutional right, such as to Article III adjudication; must be made affirmatively and in conformity with waivers of other personal constitutional rights. Such a waiver cannot be made by implication or construction. *Id.*

B. The Text And Legislative History Of ERISA Do Not Authorize A Relegation Of Judicial Power To A Conflicted Insurance Company

Not only did Congress decide not to create a *Thomas*-like regulatory scheme or a *Schor*-like waiver scheme, Congress explicitly created a regulatory scheme that grants ERISA participants and beneficiaries full and unimpeded access to the federal courts. 29 U.S.C. §1001(b) declares that it is the policy of the statute to protect the interests of participants and their beneficiaries "by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. §1132(a)(1)(B) grants participants and beneficiaries the right to commence a "civil action" and provides no limitation on the procedural protections conferred by the Federal Rules of Civil Procedure. 29 U.S.C §1132(f) provides that "the district courts shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties." 29 U.S.C §1132(e)(2) then makes it easy for participants and beneficiaries to file a civil action by creating one of the most liberal venue provisions in federal law. An action may be brought "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found."

Indeed, in early drafts of ERISA, Congress considered creating an Article I tribunal, *i.e.*, a grievance or arbitration proceeding before the Secretary of Labor,[6] to resolve disputes. The final

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[6] *See* S. Report 93-383, *reprinted in*, 1974 U.S.C.C.A.N. 4890, 4999-5000 ("the opportunity to resolve any controversy

bill, however, did not contain either of these proposals. Rather, it unambiguously provides for a private right of action in the District Courts. (29 U.S.C. §1132(f)). The fact that Congress considered and then purposefully rejected an Article I tribunal is conclusive proof that Congress did not intend to limit the Article III rights of claimants.

Because the text of ERISA is clear, the courts are not free to create a different regime when Congress chose not to. *See, American Tobacco Co. v. Patterson*, 456 U.S. 63, 68 (1982) ("'[O]ur starting point must be the language employed by Congress,' and we assume 'that the legislative purpose is expressed by the ordinary meaning of the words used'") (internal citations omitted). This Court has repeatedly described ERISA as a "comprehensive and reticulated statute," "the product of a decade of congressional study of the Nation's private employee benefit system." *See, e.g., Great-West*, 534 U.S. 204 at 209. Courts, therefore, should be very reluctant to create a non-Article III Court or tribunal that Congress did not expressly authorize. Plainly, if Congress wanted the Courts to relegate judicial power to a conflicted insurance company, it would have said so.

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over [ ] retirement benefits under qualified plans in an inexpensive and expeditious manner . . . Accordingly, the committee has decided to provide that controversies as to retirement benefits are to be heard by the Department of Labor.").

C. *Firestone* Does Not Authorize The Relegation Of Judicial Power To A Conflicted Insurance Company

The relegation of judicial power to MetLife is not authorized by *Firestone*.[7] *Firestone* never considered the applicability of Article III. Moreover, *Firestone* did not evaluate or consider the significant differences between a fully insured welfare benefit plan and a fully funded or unfunded trust. Rather, the three plans litigated before the Court were: (1) an unfunded termination pay plan; (2) an unfunded stock purchase plan; and (3) an unfunded pension plan. *Firestone* specified that its holding applied regardless of whether a plan was "funded or unfunded," *Id.* at 109, but did not specify that it applied to insured plans.

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[7] This Court held the appropriate standard of review was *de novo*, but then, in *dicta*, stated:

> Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard *unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.*

489 U.S. 101 at 109 (emphasis added). The quoted language is *dicta* because none of the plans at issue in the *Firestone* case had language granting the plan administrator or fiduciary discretionary authority. The language is, therefore, not necessary to the holding. Seizing on this *dicta*, insurance companies have readily amended their policies to include grants of discretionary authority, making the vast majority of welfare benefit claims subject to the arbitrary and capricious standard of review.

There are good reasons for treating insured plans differently from funded or unfunded plans. *Firestone* recognized the imperative of not applying a standard of review that "would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." 489 U.S. 101 at 114. Granting deference to a conflicted insurance company, however, undermines the protection of employees for the benefit of an insurance company. Historically, insurance claims have always been treated as *de novo* plenary proceedings in Court. Certainly, Congress did not intend for ERISA to make it easier for insurance companies to deny benefits to private sector employees.

Moreover, insurance cases have always been treated as breach of contract cases and have not been subject to concepts of trust law. Granting deference to a conflicted insurance company creates a total reversal of the traditional presumptions in insurance cases. Under traditional insurance law, ambiguities in insurance policies are interpreted against the insurance company under the doctrine of *contra proferentem*, not in their favor as happens under a deferential standard of review.

Since *Firestone*, the case for granting deference to a conflicted insurance company has become even more attenuated. This Court has questioned the efficacy of a deferential standard when there is a conflict of interest (as in the case of an insurance company, like MetLife, that serves as both decider and payor of benefits). *See, Rush Prudential HMO,*

Inc. v. Moran, 536 U.S. 355, 384 n.15 (2002) ("It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest.").

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

– v. –

WANDA GLENN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF FOR SOUTH BROOKLYN LEGAL SERVICES AND LEGAL SERVICES NYC AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE

South Brooklyn Legal Services ("SBLS") and Legal Services NYC, amici curiae, submit this brief pursuant to Rule 37 of the Rules of the Supreme Court of the United States. The brief is written in support of Respondent and the judgment of the United States Court of Appeals for the Sixth Circuit in *Wanda Glenn v. Metropolitan Life Insurance Company*, 461 F.3d 660 (6th Cir 2007). All parties have consented to its submission.[1]

SBLS provides free civil legal services to individuals unable to afford private counsel. Legal Services NYC supports, coordinates, and funds the work of SBLS and other affiliated offices in New York City's five boroughs. Legal Services NYC is the largest recipient of grants from the Legal Services Corporation, an independent and non-profit corporation formed and funded by Congress pursuant to the Legal Services Act, 42 U.S.C. §§ 2996, *et seq.* SBLS also receives grants from other sources, including the Administration on Aging of the United States Department of Health and Human Services, which is the principal funding source for the Mid-Atlantic Pension Counseling Project

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[1] Pursuant to Sup. Ct. Rule 37.6, counsel for amici curiae hereby certifies that this brief was authored in whole by their attorneys, and that no individual or entity other than amici curiae has contributed monetarily to the preparation or submission of this brief.

("MAPCP"), which is housed at SBLS. MAPCP provides advice and other non-litigation assistance concerning pensions and related employee benefit plans to individuals residing or formerly employed in the states of New York and New Jersey. SBLS staff have extensive first-hand knowledge of the problems people encounter when they try to learn about, or exercise their right to, benefits for which they are eligible due to age, injury or infirmity. In the experience of SBLS lawyers, of all the obstacles these men and women face, none is greater than the deferential judicial review of benefit denials.

SUMMARY OF ARGUMENT

1. Under the Employee Retirement Income Security Act ("ERISA" or "the statute") participants have actions for benefits presumptively decided de novo without deference to the plan administrator. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989) ("*Bruch*"). Although plan documents may give the trustee discretionary authority, "if a plan gives discretion to an administrator or fiduciary who is operating under a possible or actual conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

While most circuits have given significant weight to conflicts of interest, some courts of appeals have forged a peculiar definition of

"conflict of interest" that does not encompass an objective conflict of economic interest unless the aggrieved participant is somehow able to demonstrate that the benefit denial was subjectively affected by the conflict. Petitioners have asked this Court to adopt this definition

The United States Court of Appeals for the Second Circuit is one of the courts of appeals that has already granted Petitioners' wish. Our survey of cases decided by the four district courts located in New York State, the courts which hear the great majority of cases filed within the circuit, have shown that, in practice, the application of this definition has placed a burden on plaintiffs that, except in rare cases, they simply cannot carry. In fact, the burden was carried in only 2 of 65 cases.

2. The deferential standard of review applied to decisions by administrative agencies is inappropriate for conflicted plan administrators because plans lack the procedural protections required of agencies, including a trial-like hearing presided over by an impartial adjudicator.

3. The deferential standard Petitioners seek would violate Congress's intent to give civil actions, in the district courts, a primary role in protecting participants right to a hearing presided over by an adjudicator whose interests do not conflict with the claimant's. In ERISA Congress broadly empowered the federal courts to serve as a "safety net," replacing and enlarging the remedies previously available in state court.

ARGUMENT

1. ADOPTING PETITIONERS' DEFERENTIAL APPROACH TO REVIEW OF DECISIONS BY DUAL-ROLE INSURERS WOULD EVISCERATE THE PROTECTION FOR PARTICIPANTS PROVIDED BY *BRUCH*

The case before this Court places in sharp focus an anomaly: Since *Firestone Tire & Rubber Company v. Bruch*, 489 U.S. 101 (1989), ERISA-fiduciary decisions have been presumptively subject to de novo review, whereas the great majority of cases decided since *Bruch* have been reviewed under the extremely deferential "arbitrary or capricious standard." This anomaly is a consequence of the almost universal insertion, in the aftermath of *Bruch*, of self-serving clauses endowing plan fiduciaries with discretionary authority. *See* Donald T. Bogan & Benjamin Fu, ERISA: *No Further Inquiry Into Conflicted Administrator Denials*, 58 Okl. L. Rev. 637, 647-648 (2006); John H. Longbein, Trust Law as Regulatory Law: *The Unum/Provident Scandal and the Review of Benefit Denials After ERISA*, 101 Nw. U.L. Rev. 1315, 1324 (2007); *see also Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383 n.2 (3d Cir. 2000).[2]

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[2] It need not be argued strenuously that the process of plan amendment was rarely one of arms length bargaining. This is particularly so in light of the dramatic diminution, since ERISA was enacted, in the percentage of benefit plans whose terms were determined

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Predictably, the companies have used these clauses as a basis for obtaining deferential judicial review. As authority they have pointed to the *Bruch* court's passing reference to the old rule that "a court of equity will not interfere to control" a trustee who exercises in "a discretion vested in them by the instrument with which they act." *Bruch*, 489 U.S. at 112, (quoting *Nichols v. Eaton*, 472 U.S. 716, 724-725 (1875)). Just as predictably, they have rarely acknowledged the Court's observation that "[o]f course, if a plan gives discretion to an administrator or fiduciary who is operating under a possible or actual conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion." *Bruch*, 489 U.S. at 115, (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). To the disappointment of plan administrators with conflicts of interest, the majority of courts of appeals have striven, in

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through a process of collective bargaining. Today virtually all benefit plans are contracts of adhesion. *See* John H. Longbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and the Review of Benefit Denials After ERISA*, 101 Nw. U.L. Rev. 1315, 1323 (2007) (ERISA plans are characteristic contracts of adhesion, offered on a take the job or leave it basis. As a practical matter the employee has no opportunity to bargain with the employer on such matters as the standard of review of benefit denials."); *see also* Alison M. Sulentic, *Secrets Lies & ERISA: The Social Ethics of Misrepresentations and Omissions in Summary Plan Descriptions*, 40 J. Marshall L. 731 (2007).

accordance with *Bruch*, to temper their deference to their decisions by considering their conflict "as a factor." To do this, these eight courts of appeal use varying forms of "sliding scale" analysis to determine the degree of deference appropriate in each particular case. In addition, two courts of appeal have sanctioned the use of burden-shifting. *See* Brief Amicus Curiae Brief of the United States in Support of Petition for Writ of Certiorari at 7-10 (describing different approaches.)

A minority of courts of appeals have taken a different approach. These courts have forged a peculiarly narrow definition of "conflicts of interest," indeed, a definition so narrow that, in these circuits meaningful judicial review in such cases has all but ceased to exist. In the circuits that have taken this approach, an administrator whose assets are diminished each time it grants a claim is not presumed to have interests in conflict with those it adjudicates. Such a conflict only exists if the participant somehow manages to demonstrate to the court that "the administrator was in fact influenced by such conflict." *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d. Cir. 1996).[3] Absent such a showing, the court reviews the

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[3] This is the position taken in the first, second, and seventh circuits. *See, e.g., Wright v. R.R. Donnelly & Sons Co. Group Benefits Plan*, 402 F.3d 67 (1st Cir. 2005); *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (7th Cir. 1999); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438 (2d Cir. 1996).

decision under the deferential arbitrary or capricious standard. Unsurprisingly, this is the approach that Petitioners have asked this Court to impose nationally.

There is no need to speculate about what the consequences will be if Petitioners have their way; one need only look at what has happened where their proposed rule has already been adopted. Simply put, the effect has been a judicial regime of passive acquiescence to virtually all fiduciary decisions, irrespective of whether the courts themselves believe the decisions to be unfair or mistaken.

This is demonstrated, for example, by a review of the cases in which the issue was raised and resolved by one of the four district courts in New York State since the United States Court of Appeals for the Second Circuit first adopted this approach in *Pagan v. NYNEX Pension Plan*, 52 F.3d 438 (2d Cir. 1996). Of the 65 published or electronically available cases, only two found the plaintiff able to carry the burden.[4]

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[4] The two cases are *Diamond v. Treasurers & Ticket Sellers Union Local 751 Pension Fund*, No. 05 Civ. 1937, 2006 WL 2462907 (S.D.N.Y. Aug. 22, 2006) (plaintiff demonstrated that personal animus by plan manager affected decision); and *Schwartz v. Oxford Health Plans*, 175 F. Supp. 2d 581, 590-91 (S.D.N.Y. 2001) (plaintiff demonstrated conflict of interest affected denial of monies for cancer treatment). In a third case, not included in the total, also from the Southern District, *Suozzo v. Bergreen*,

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No. 00 CIV. 9649, 2002 WL 1402316 (S.D.N.Y. June, 27, 2002), the court refused to decide the issue on a motion to dismiss inasmuch as the court did not yet have the administrative record. The ultimate resolution of the issue is unknown. The cases in which the plaintiff failed to carry the burden are: *Bacquie v. Liberty Mut. Ins. Co.*, 247 Fed. Appx. 296 (2d Cir. 2007); *Russo v. Continental Cas. Co.*, 214 Fed. Appx. 7 (2d Cir. 2007); *Flanagan v. First Unum Life Ins.*, 170 Fed. Appx. 182 (2d Cir. 2006); *Smith v. First UNUM Life Ins. Co.*, 157 Fed. Appx. 332 (2d Cir. 2005); *Waksman v. IBM Separation Allowance Plan*, 138 Fed. Appx. 370 (2d Cir. 2005); *Kirk v. Readers Digest Ass'n.*, 57 Fed. Appx. 20 (2d Cir. 2003); *Krizek v. Cigna Group Ins.*, 345 F.3d 91 (2d Cir. 2003); *Caidor v. Chase Manhattan Bank*, 29 Fed. Appx. 704 (2d Cir. 2002); *Fay v. Oxford Health Plan*, 287 F.3d 96 (2d Cir. 2002); *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89 (2d Cir. 2000); *Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475 (2d Cir. 1997); *Sullivan v. LTV Aerospace & Defense Corp.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996); *Meehan v. Atlantic Mut. Ins. Co.*, No. 06-CV-3265, 2008 WL 268805 (E.D.N.Y. Jan. 30, 2008); *Gannon v. Aetna Life Ins. Co.*, No. 05 Civ. 2160, 2007 WL 2844869 (S.D.N.Y. Sept. 28, 2007); *Fedderwitz v. Metropolitan Life Ins. Co., Inc.'s Disability Unit*, No. 05 CV 10193, 2007 WL 2846365 (S.D.N.Y. Sept. 27, 2007); *McGann v. Travelers Property Cas. Corp.*, No. 06-CV-527, 2007 WL 2769500 (E.D.N.Y. Sept. 21, 2007); *Guglielmi v. Northwestern Mut. Life Ins. Co.*, No. 06 Civ. 3431, 2007 WL 1975480 (S.D.N.Y. July 6, 2007); *McCauley v. First UNUM Life Ins. Co.*, No. 07 Civ. 7662, 2006 WL 2854162 (S.D.N.Y. Oct. 5, 2006); *Greenberg v. Unum Life Ins. Co. of Amer.*, No. CV-03-1396, 2006 WL 842395 (E.D.N.Y. Mar. 27, 2006); *Harrison v. Metropolitan Life Ins. Co.*, 417 F. Supp. 2d. 424 (S.D.N.Y. 2006); *Pelosi v. Schwab Capital Mkts., L.P.*, 462 F. Supp. 2d 503 (S.D.N.Y. 2006); *Nelson v. Unum Life Ins. Co. of Amer.*, 421 F. Supp. 2d 558 (E.D.N.Y. 2006); *Marasco v. Bridgestone/Firestone, Inc.*, No. 02-CV-6257, 2006 WL 354980 (E.D.N.Y. Feb. 15, 2006); *Lee v. Aetna*

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Life & Cas. Ins. Co., No. 05 Civ. 2960,2006 WL 345854 (S.D.N.Y. Feb. 13, 2006); *Badawy v. First Reliance Standard Life Ins. Co.*, No. 04 Civ. 01619, 2005 WL 2396908 (S.D.N.Y. Sept. 28, 2005); *Anderson v. Sotheby's Inc. Severance Plan*, No. 04 Civ. 8180, 2005 WL 2583715 (S.D.N.Y. Oct. 11, 2005); *Pava v. Hartford Life & Accident Ins. Co.*, No. 03 CV 2609, 2005 WL 2039192 (E.D.N.Y. Aug. 24, 2005); *Nerys v. Building Service 32B-J Health Fund*, No. 03 Civ. 0093, 2004 WL 2210256 (S.D.N.Y. Sept. 30, 2004); *Owen v. Wade Lupe Constr. Co.*, 325 F. Supp. 2d 146 (N.D.N.Y. 2004); *Chan v. Hartford Life Ins. Co.*, No. 02 Civ. 2943, 2004 WL 2002988 (S.D.N.Y. Sept. 8, 2004); *Snyder v. First Unum Life Ins. Co.*, No. 02-CV-889S, 2004 WL 1784334 (W.D.N.Y. Aug. 6, 2004); *Shutts v. First Unum Life Ins. Co.*, 310 F. Supp. 2d 489 (N.D.N.Y. 2004); *Tocker v. Philip Morris Cos. Inc.*, 346 F. Supp. 2d 460 (S.D.N.Y. 2004); *Cook v. New York Times Co. Long-Term Disability Plan*, No. 02 Civ. 9154, 2004 WL 203111 (S.D.N.Y. Jan. 30, 2004); *Couture v. UNUM Provident Corp.*, 315 F. Supp. 2d 418 (S.D.N.Y. 2004); *Wagner v. First Unum Life Ins. Co.*, No. 02 Civ. 9135, 2003 WL 21960997 (S.D.N.Y. Aug. 13, 2003); *Doe v. Cigna*, 304 F. Supp. 2d 477 (W.D.N.Y. 2003); *Bergquist v. Aetna U.S. Healthcare*, 289 F. Supp. 2d 400 (S.D.N.Y. 2003); *Armstrong v. Liberty Mut. Life Assur. Co.*, 273 F. Supp. 2d 395 (S.D.N.Y. 2003); *Scannell v. Metropolitan Life Ins. Co.*, No. 03 Civ.990, 2003 WL 22722954 (S.D.N.Y. Nov. 18, 2003); *Henar v. First Unum Life Ins. Co.*, No. 02 Civ. 1570, 2002 WL 31098495 (S.D.N.Y. Sept. 19, 2002); *Maniatty v. Unumprovident Corp.*, 218 F. Supp. 2d 500 (S.D.N.Y. 2002); *Rosenthal v. First Unum Life Ins. Co.*, No. 00 CIV. 3204, 2002 WL 975627 (S.D.N.Y. May 9, 2002); *Thompson v. General Elec. Co.*, No. 01 Civ. 4438, 2002 WL 482862 (S.D.N.Y. Mar. 29, 2002); *Zervos v. Verizon New York, Inc.*, No. 01 CIV 685, 2001 WL 1262941 (S.D.N.Y. Oct. 22, 2001), *rev'd on other grounds*, 277 F.3d 635 (2d Cir. 2002); *Corvi v. Eastman Kodak Co. Long Term Disability Plan*, No. 01 CIV 365, 2001 WL 484008 (S.D.N.Y. May 8, 2001); *Flynn v. Hach*, 138 F. Supp. 2d

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The reasons for this are not difficult to discern. Even in the minority of cases in which there is "a smoking gun" that shows that the conflict affected the decision, it is rarely, if ever, in the possession of the plaintiff, the party carrying the burden of proof. And even when discovery is allowed, it is unlikely that the ordinary participant or beneficiary has the level of resources that enabled, for example, a team of government lawyers to conduct the kind of wide ranging investigation that led to the uncovering of Unum's biased clams adjudication. *See* Brief for Respondent at 16-17.

The impracticality and unfairness of using this subjective definition is implicitly indicated by the fact that it is not the one used in the law of trusts or in the rules that govern the disqualification of adjudicators ranging from judges to baseball umpires. *Id.* at 16. This is

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334 (E.D.N.Y. 2001); *Bjork v. Eastman Kodak Co.*, 189 F. Supp. 2d 3 (W.D.N.Y. 2001); *Turay v. Aetna U.S. Healthcare*, 160 F. Supp .2d 557 (S.D.N.Y. 2001); *Risenhoover v. Bayer Corp.*, 83 F. Supp. 2d 408 (S.D.N.Y. 2000); *Administrative Comm. of the Time Warner, Inc. Benefit Plans v. Biscardi*, No. 99 CIV. 12270, 2001 WL 286749 (S.D.N.Y. Mar. 21, 2001); *Boesel v. The Chase Manhattan Bank*, 62 F. Supp. 2d 1015 (W.D.N.Y. 1999); *Weissman v. First Unum Life Ins. Co.*, 44 F. Supp. 2d 512 (S.D.N.Y. 1999); *DeVere v. Northrop Grumman Corp.*, No. 97-CV-3324, 1999 WL 182670 (E.D.N.Y. Mar. 24, 1999); *Elsroth v. Consolidated Edison*, 10 F. Supp. 2d 427 (S.D.N.Y. 1998); *Semmler v. Metropolitan Life Ins. Co.*, 172 F.R.D. 86 (S.D.N.Y. 1997).

not surprising. As the United States pointed out, at the time *Bruch* was argued, it is "illogical to assume that administrators . . . whose benefits are paid from the employer's assets will function with the same impartiality as a neutral trustee of a funded plan, since the administrator's employer will sustain a financial loss with every award of benefits. Despite Firestone's insistence that self-interest played no role in its denial of respondents' claims, and whether or not it did in this case, the members of this Court need not 'close [their] eyes to what [they] must perceive as men." Brief for United States as Amicus Curiae in *Bruch* at 11-12. (quoting *People ex. Rel. Portland Cement Co, v. Knapp*, 230 N.Y. 48, 63, 129 N.E. 202, 208, *cert. denied*, 256 U.S. 702 (1921) (brackets added by government; citation to petitioner's brief omitted)).

2. THE DEFERENCE ACCORDED ADMINISTRATIVE AGENCIES SHOULD NOT BE EXTENDED TO DUAL ROLE ADMINISTRATORS BECAUSE BENEFIT PLANS DO NOT PROVIDE THE PROCEDURAL PROTECTIONS REQUIRED OF AGENCIES

It is ironic that some courts have come to cite *Bruch* as authority for treating ERISA-plan decisions as if they were administrative decisions, and for adopting from administrative law the "arbitrary and capricious" standard in reviewing those decisions. The applicability of that standard was the central contention of the employer in *Bruch*, and almost the entire

decision is devoted to its refutation. The Court's rejection of the employer's argument was not based on an abstract application of trust law but on the Court's recognition that Congress had used trust law as a means of effecting its goal of "promot[ing] the interests of employees and their beneficiaries in employee benefit plans." *Bruch*, 489 U.S. at 114 (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983)).

Even if ERISA did not "abound with the language and terminology of trust law," *Bruch*, 489 U.S. at 109, the application of administrative law's deferential standard of review to ERISA claim denials by dual role administrators would be illogical because ERISA claimants do not enjoy *any* of the procedural safeguards provided by administrative agencies. *See Ramsey v. Hercules, Inc.*, 77 F. 3d 199, 205 (7th Cir. 1996); *Brown v. Blue Cross and Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1564 n.7 (11th Cir. 1990).

To list the safeguards that claimants before federal agencies enjoy, but which ERISA claimants do not, is to list the elements of fairness itself. Above all, agency claimants enjoy the right to a full evidentiary hearing, 5 U.S.C. § 554(c)(2), "conducted in an impartial manner" by a duly appointed administrative law judge or other impartial decision-maker, 5 U.S.C. § 556(a). These adjudicators are "functionally comparable" to federal judges. *Federal Maritime Comm'n v. South Carolina State Ports Auth.*, 535 U.S. 743, 756-57 (2002) (quoting *Butz v. Economou*, 438 U.S. 478, 513 (1978)) (citation

omitted). They have the power to issue subpoenas, 5 U.S.C. § 556(b)(2), the power to "rule on offers of proof and receive relevant evidence," 5 U.S.C. § 556(b)(3), the power to take or require the taking of depositions "when the ends of justice would be served," 5 U.S.C. § 556(b)(4), and the power to "regulate the course of the hearing," 5 U.S.C. § 556(b)(5). *See Federal Maritime Comm'n*, 438 U.S. at 513. And if, despite these safeguards, the agency fact-finding process is found to be inadequate, a reviewing court applies de novo review. *See* 5 U.S.C. § 706(2)(f).

Crucial to this scheme is the impartiality of the agency and of the men and woman it employs to hear and decide claims. Their impartiality, of course, requires the absence of any objective conflicts of interest. *See* Brief for Respondent at 16-17, 25-30 and authorities cited therein. When an agency decision-maker does have such a conflict, it is redressed not through judicial review—heightened or otherwise—but simply by disqualification. *See Gibson v. Berryhill*, 411 U.S. 564, 579 (1972); Kenneth C. Davis, *Administrative Law Text* § 12.04, p. 250 (1972). All told, the elements of the administrative process, which mirror those used by courts, simultaneously fulfill the requirements of due process and decrease the likelihood of an erroneous decision.

The similarities of the procedures used by administrative agencies and courts, and of the corresponding reliability of their decisions, put into sharper relief the qualitative difference

between administrative adjudication and decision-making by conflicted ERISA fiduciaries. This qualitative difference was addressed by Judge Posner when he observed, with reference to adjudications made by the Social Security Administration, that such decisions were made by "a public agency that denies benefits only after giving an applicant an opportunity for a full and fair adjudicative hearing before a judicial officer, an administrative law judge. The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by plan administrators." *Herzberger v. Standard Ins.* Co., 205 F.3d 327, 332 (7th Cir. 2000).

3. A DEFERENTIAL STANDARD OF REVIEW FOR CONFLICTED ADMINISTRATORS WOULD VIOLATE CONGRESS'S INTENTION THAT PARTICIPANTS BE PROTECTED THROUGH THE COURTS

Congress could have provided claimants with an authentic administrative process with all the safeguards mentioned in the last argument. In fact, Congress considered, but decided against, creating an administrative agency to adjudicate claims in the manner of other federal agencies. *See* 2 Subcommittee on Labor of the Senate Committee on Public Labor and Public Welfare, 94th Cong. 2d Sess. Legislative History of the Employee Retirement Security Act of 1974, 1835-1836 (Comm. Print 1976). As an alternative, Congress chose to protect participants by making plan administrators their fiduciaries, e.g., 29 U.S.C. § 1104, and by providing participants

with "appropriate remedies, sanctions, and ready access to the courts." 29 U.S.C. § 1001(b).

To this end, Congress enlarged district court jurisdiction to encompass suits brought by participants against benefit plans for failure to furnish them with plan documents, 29 U.S.C. § 1132(a)(1)(A); for monies due to them under the terms of the those documents, 29 U.S.C. § 1132(a)(1)(B); and for breach of fiduciary duty, 29 U.S.C. § 1109. Congress further endowed the courts with full equity jurisdiction in ERISA cases so they could serve as "a safety net offering appropriate equitable relief" to redress violations of ERISA that could not be remedied through any of the other statutory claims. *Varity v. Howe*, 516 U.S. 489, 512 (1996) (citing 29 U.S.C. § 1132(a)(3)). And, "in order to remove a possible procedural obstacle to having all proper parties before the court," Congress provided participants with nationwide service of process, H.R. Rep. 93-533, 93rd Cong., 2nd Sess. (Oct. 2, 1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4655; *see* 29 U.S.C. § 1132(e)(2), provided exceptionally liberal venue provisions, 29 U.S.C. § 1132(e)(2), and gave judges the power to award attorney fees, 29 U.S.C. § 1132(g).

Each of the claims that ERISA affords participants is referred to as a "civil action," 29 U.S.C. § 1132(a), and nothing suggests that this phrase has anything other than its ordinary meaning. No reference is made to phrases such as "arbitrary and capricious," "abuse of discretion," or "substantial evidence," phrases that are easily recognized as signposts for the

deferential review of administrative proceedings. When Congress intends to limit the scope of district court review, it uses specific terms of art. As this Court has explained, "[i]n most instances, of course, where Congress intends review to be confined to the administrative record, it so indicates either expressly or by the use of terms like 'substantial evidence,' which has 'become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court." *Chandler v. Roudebush*, 425 U.S. 840, 862 (1976) (quoting *United States v. Bianchi & Co.*, 373 U.S. 709, 713 (1963)).

The typical pre-ERISA remedy was an action for breach of contract "in which the [state] court reviewed the employees' claim as it would any other contract claim . . . ." *Bruch*, 489 U.S. at 111. *See, e.g., Strickland v. American Confectionary & Bakers Union*, 1974 Ok. 111, 527 P.2 10 (1974) (contract action); *Jacoby v. Grays Harbor Chair & Mfg. Co.*, 77 Wash. 2d 911, 468 P.2d 666 (1970) (contract action decided after jury trial); *Ellis v. Emhart Mfg. Co.*, 151 Conn. 501, 891 A.2d 546 (1963) (contract action); *Frietzche v. First Western Bank & Trust Co.*, 168 Cal. App. 705, 336 P.2d 589 (1959) (action for declaration of contractual rights decided de novo); *Sigman v. Rudolph Wurlitzer*, 57 Ohio App. 4, 11 N.E.2d 878 (1937) (contract action decided after jury trial).

ERISA's preemption clause, which deprived state courts of the power to try such suits, was not intended to reduce the ability of participants to obtain judicial redress. As the legislative

history makes clear, Congress intended that the federal courts would be, if anything, more protective of participants than the state courts had been. See H.R. Rep. 93-533, 93rd Cong., 2nd Sess. (Oct. 2, 1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4655. Under ERISA, the courts were expected to provide participants "the full range of legal and equitable remedies available in both state and federal courts." H.R. Rep. 93-533, 93rd Cong., 2nd Sess. (Oct. 2, 1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4655. Thus in *Bruch*, the Court, in rejecting the employer's argument against de novo review, observed that, requiring anything less "would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Bruch*, 489 U.S. at 114.

CONCLUSION

For the foregoing reasons, the decision of the United States Court of Appeals for the Sixth Circuit should be affirmed.

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IN THE

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

– v. –

WANDA GLENN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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STATEMENT OF INTEREST

Amici and counsel are a group of law professors who teach, study, and write about trust law and/or ERISA law, and who have closely followed this Court's application of trust law to ERISA.[1] Among the group are law professors who are co-authors of leading casebooks and treatises in the field of Trusts and Estates and ERISA. Amici include:

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[1] The parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission.

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SUMMARY OF ARGUMENT

I. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court, relying on trust law principles, stated that when a benefit plan "gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion." MetLife's primary argument is that a plan administrator who also pays benefits has no conflict of interest unless the claimant can establish that the plan administrator "was motivated by its own self-interest" in reaching its decision. (Petr.'s Br. 16). This argument misunderstands trust law, which sharply distinguishes between conflict of interest and trustee misconduct.

In trust law, a conflict of interest exists when a trustee is in a position to benefit personally from decisions he is authorized to make by the terms of the trust. Trust law recognizes that a trustee will be tempted, consciously or unconsciously, to act unfairly when the interests of the trust beneficiaries conflict with the trustee's personal financial interests. Metlife, the plan administrator, faces a conflict of interest because under its arrangement with the employer, Metlife gets to keep each dollar saved when Metlife concludes that a plan beneficiary is not entitled to benefits.

Moreover, if MetLife's theory were adopted, a conflict of interest would never be "weighed as a 'facto[r] in determining whether there is an abuse

of discretion,'" directly violating this Court's command that it "must be weighed." *Firestone*, 489 U.S. at 115 (citation omitted). If a claimant can prove that the plan administrator was actually motivated by self-interest when terminating benefits (the standard articulated by Metlife), there is nothing to weigh; the plan administrator's decision would automatically be vacated. Metlife's theory, then, is inconsistent with the opinion in *Firestone*, as well as with basic principles of trust law.

II. When a plan administrator has a conflict of interest and discretion to distribute plan benefits, the situation is directly analogous to the trustee who is also a remainder beneficiary of the trust, but has discretion to make distributions to one or more income beneficiaries. Both the plan administrator and the trustee are residual claimants who benefit when they deny a claim for distribution. Just as an ERISA plan administrator must exercise discretion to determine whether an employee is "permanently disabled" or "ill", trustees are required to make distributions of trust property pursuant to an objective standard, such as "support," "health" or "education."

When a trust beneficiary challenges the distribution decision of a self-interested trustee, courts focus not on language conferring discretion on that self-interested trustee, but on the standard set out in the trust instrument. Courts carefully scrutinize the trustee's decision to ensure that the self-interested trustee did not exercise its discretion in a way that undermines the trust's objectives.

When they do conclude that the trustee has acted on its conflict of interest to frustrate the trust's purposes, courts hold that the trustee has abused its discretion. Thus, in trust law, the term "abuse of discretion" does not refer to a standard of judicial review, but rather reflects a legal conclusion, most often reached after discovery and trial, that the trustee exercised its discretion in a manner inconsistent with the terms of the trust instrument or the purpose of the trust.

III. ERISA is a regulatory statute designed to protect the beneficiaries of employee benefit plans. Although the common law of trusts serves as the foundation for ERISA's fiduciary duty rules, ERISA's purpose is primarily regulatory rather than enabling. Therefore, ERISA permits even less modification of fiduciary duties than would be permitted under the common law of trusts.

ARGUMENT

I. WHEN THE TRUSTEE'S EXERCISE OF DISCRETION HAS THE POTENTIAL TO BENEFIT THE TRUSTEE PERSONALLY, THE TRUSTEE OPERATES UNDER A CONFLICT OF INTEREST, EVEN IF THE TRUSTEE ENGAGES IN NO MISCONDUCT.

The duty of loyalty, which is fundamental to the law of trusts, generally requires trustees to "administer the trust solely in the interest of the beneficiaries" and prohibits trustees from

"engaging in transactions that involve self-dealing." RESTATEMENT (THIRD) OF TRUSTS § 78 (1) and § 78 (2) (2003). ERISA is built on the trust law model; tracking trust law language, ERISA provides, subject to exceptions not applicable in this case, that "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. §1104(a)(1).

In its opinion in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court recognized that ERISA benefit determinations can present conflict of interest problems, and indicated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* at 115 (quoting RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)). This focus on conflicts of interest limited the power of employers to immunize benefit denials from meaningful judicial review by inserting "magic words" into the relevant plan documents.

MetLife has argued that there is no conflict, and hence no occasion for careful scrutiny of the plan administrator's determination, unless "a plaintiff is able to make a showing that the fiduciary was actually infected by self-dealing when making the challenged decision." (Petr.'s Br. at 25). This argument is inconsistent with both language and logic. If a plaintiff could show that the fiduciary was "infected by self-dealing" in making a concrete benefits decision, no heightened scrutiny would be necessary; the demonstration that the plan

administrator acted out of an improper motive in denying a beneficiary's claim would, by itself, require that the decision be annulled. The Court's conclusion that a conflict "must be weighed" in determining whether there has been an abuse of discretion necessarily contemplates that a "conflict" can exist without proof that the plan administrator's decision was "infected by self-dealing."

In reaching a result consistent with the logic of this Court's opinion in *Firestone*, the Sixth Circuit has concluded in this case that a claim administrator of an ERISA plan who also funds the plan benefits operates under a conflict of interest, and thus triggers more searching judicial review. That conclusion, consistent with the common law of trusts, has been endorsed by the majority of other Courts of Appeals to address the issue. *See, e.g., Post v. Hartford Ins. Co.*, 501 F.3d 154, 161-164 (3d Cir. 2007); *Carolina Care Plan Inc. v. McKenzie*, 467 F.3d 383, 386-387 (4th Cir. 2006), *cert. dismissed*, Nos. 06-1182 & 06-1436 (July 30, 2007); *Vega v. National Life Ins. Servs., Inc.*, 188 F.3d 287, 295-296 (5th Cir. 1999) (en banc); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-966 (9th Cir. 2006) (en banc); *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561, 1566-1567 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991). These courts recognize that proof of misconduct is not necessary to establish the existence of a conflict of interest. By contrast, if a trust beneficiary establishes that self-interest

improperly affected the trustee's decision, the beneficiary has established a breach of trust; the existence of a conflict of interest becomes entirely irrelevant.

Trust law generally prohibits a trustee from engaging in transactions with the trust, even if the trustee's actions do not harm the trust beneficiaries. The prohibition on unauthorized trustee self-dealing is designed to ensure that the trustee does not place its personal interests ahead of the interests of the trust beneficiaries:

> [I]t is generally, if not always, humanly impossible for the same person to act fairly in two capacities and on behalf of two interests in the same transaction. Consciously or unconsciously he will favor one side as against the other, where there is or may be a conflict of interest. If one of the interests involved is personal to the trustee, selfishness is apt to lead him to give himself an advantage.

GEORGE GLEASON BOGERT ET. AL, TRUSTS & TRUSTEES §543 (rev. 2d ed. 1993). As a result, unless the trust settlor authorized the trustee to act despite his conflict of interest, courts conclusively presume that the conflict affected the trustee's decision. It is "immaterial that the trustee may be able to show that the action in question was taken in good faith, that the terms of the transaction were fair, and that no profit resulted to the trustee." RESTATEMENT (THIRD) OF TRUSTS §78 cmt. b (2003).

A trust instrument may, expressly or implicitly, authorize a trustee to engage in transactions with

the trust, despite the inherent conflict of interest. But express authorization does not make the conflict of interest disappear. It merely relieves the trustee from the absolute prohibition on self-dealing. *See In re Flagg's Estate*, 73 A.2d 411 (Pa. 1950) (holding that when settlor names trustee with knowledge that the trustee has a conflict, the settlor's authorization "necessarily modified or displaced the otherwise absolute limitation against self-dealing"). Instead of conclusively presuming that the conflict affected the trustee's decision, a court will scrutinize the transaction to ensure that it furthers the settlor's objective in creating the trust and authorizing the conflict. *See* RESTATEMENT (THIRD) OF TRUSTS §37, cmt. f(1) (2003)("when a beneficiary serves as trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny"); 3 SCOTT AND ASCHER ON TRUSTS SEC. 18.2 (5TH ED. 2007) (recognizing that court reviewing whether trustee has abused discretion should take account of "the existence or nonexistence of an interest of the trustee that conflicts with an interest of any of the beneficiaries," among other factors).

Trust law recognizes that settlor-authorized conflicts are conflicts nevertheless, even if the conflict does not lead to breach of fiduciary duty. *See, e.g., Clement v. Larkey*, 863 S.W.2d 580, 582 (Ark. 1993)(recognizing that when trust settlor names trustee as beneficiary "conflicts of interest and coincidental benefits to that trustee-beneficiary inevitably result")(quoting RESTATEMENT (SECOND) OF TRUSTS §99 (1957)). Courts have often

distinguished between conflict of interest and fiduciary misconduct, concluding that when the dispositive instrument confers on the fiduciary discretion to act in ways that might benefit the fiduciary personally, the fiduciary's actions are subject to close judicial scrutiny, but do not constitute misconduct if they advance the purpose of the dispositive instrument. For example, in *Goldman v. Rubin*, 441 A.2d 713 (Md. 1982), the Maryland Court of Appeals distinguished between conflict of interest and misconduct: "the personal representatives have not breached their trust simply from the fact that one or more of them had conflicting personal interests." *Id.* at 724.

Trust law also distinguishes between conflict of interest and trustee misconduct in cases where trust beneficiaries seek removal of a trustee who has a conflict. For instance, in *In re Foss' Will*, 125 N.Y.S.2d 105, 109 (N.Y. App. Div. 1953), the court refused to remove a co-executor, despite an apparent conflict of interest, because "[m]isconduct, not conflict in interest, merits removal of a fiduciary." Testator had named his lawyer, who was officer, director, and house counsel of a firm against whom testator's estate had a contract claim, as a co-executor of his will. Legatees under the will objected to the lawyer's appointment, citing the conflict of interest. In rejecting their claim, the court noted that if the conflict of interest ripened into misconduct, the "objectants will not be left without remedy." *Id. See also Lovett v. Peavy*, 316 S.E.2d 754, 757 (Ga. 1984)(trustees who were also remaindermen not removed, despite their temptation to "favor themselves unduly in the

administration of the trust"); *Whan v. Whan*, 542 S.W.2d 7, 11 (Mo. Ct. App. 1976) ("conflict of interest alone need not compel a court to remove trustees," but breach of duty justified removal).

The Restatement (Third) of Trusts also makes it clear that the trustee's potential to benefit from its fiduciary position creates a conflict of interest, even if settlor's knowledge of the conflict does not justify removal of the trustee. A comment to Section 37 (Removal of Trustees) provides:

> [T]he fact that the trustee named by the settlor is one of the beneficiaries of the trust, or *would otherwise have conflicting interests,* is not a sufficient ground for removing the trustee . . . .

RESTATEMENT (THIRD) OF TRUSTS §37 cmt f(1) (2003)(emphasis added). The comment goes on to provide that "when a beneficiary serves as trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." *Id.*

Hence, the common law of trusts, both in doctrines relating to judicial review of trustee decisions, and in doctrines concerned with removal of trustees, has established that a conflict of interest can exist without fiduciary misconduct -- the common sense conclusion reached by the Sixth Circuit in this case.

II. WHEN A TRUST INSTRUMENT CONFERS DISCRETION ON A TRUSTEE WHO IS ALSO A BENEFICIARY, COURTS CAREFULLY SCRUTINIZE TRUSTEE DECISIONS DENYING PAYMENT TO OTHER BENEFICIARIES TO ENSURE THAT THE PAYMENT DENIAL IS CONSISTENT WITH THE STANDARD ARTICULATED IN THE INSTRUMENT.

In *Firestone,* this Court, after holding that benefit determinations by ERISA plan administrators should generally be subject to *de novo* judicial review, suggested that the holding would apply "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989). The Court identified trust law as the source for this exception: "Neither general principles of trust law nor a concern for impartial decision making, however, forecloses parties from agreeing upon a narrower standard of review." *Id.* But the Court also recognized that even when the employer confers discretion on a plan administrator, courts must consider an administrator's conflict of interest in reviewing the administrator's exercise of discretion. *Id.*

These two conclusions accurately restate established principles of trust law, but do not fully capture the limits on a trust settlor's power to insulate a trustee from judicial review. First,

"abuse of discretion" is a conclusion of law, not a standard of review. A court determining whether a trustee has abused its discretion never simply refers to the language of the trust or applies any other simple formula. Instead, the beneficiary is entitled to whatever discovery state law allows, followed by a trial on the merits. Second, whenever a trust instrument confers discretion on a trustee with a conflict of interest, and imposes standards on the trustee's exercise of discretion, a court will scrutinize the trustee's decision to ensure that it is consistent with the standard and the trust's objectives.

A. In the Law of Trusts, "Abuse Of Discretion" is not a Standard of Review, but a Legal Conclusion that the Trustee's Exercise of Discretion Constituted Breach of Fiduciary Duty

MetLife relies on the law of trusts to argue that the determination of an ERISA plan administrator with a pecuniary interest in denying benefits should be subject to judicial scrutiny for "abuse of discretion." MetLife then takes the argument one step further by contending that the "abuse of discretion" standard "closely resembles" the "arbitrary and capricious" standard applied to review of many administrative determinations. (Petr.'s Br. at 34). These contentions misunderstand the law of trusts.

In trust law, "abuse of discretion" is not a standard of review at all, but a legal conclusion, most often reached after discovery and a trial, that

the trustee exercised its discretion in a manner inconsistent with the terms of the trust instrument or the purpose of the trust. Whenever a trust instrument confers discretion on a trustee, and the court concludes that the trustee's exercise of that discretion breached a duty to a trust beneficiary, a court is apt to conclude that the trustee "abused its discretion." This conclusion, however, says nothing about the level of scrutiny the court applied to the trustee's determination. Thus, in discussing abuse of discretion, the Restatement (Third) of Trusts provides, "judicial intervention on the ground of abuse is called for ... because the trustee's decision is one that would not be accepted as reasonable by persons of prudence. Thus, a court may properly interpose if it finds that the trustee's conduct, in exercising a discretionary power, fails to satisfy the applicable standard of care and skill." RESTATEMENT (THIRD) OF TRUSTS §87 cmt. c (2003).

This focus on "reasonableness," "prudence, "care," and "skill" bears no relationship to the "arbitrary and capricious" standard familiar to administrative law. Moreover, the language of the trust instrument may constrain or expand the trustee's discretion in countless ways, making it impossible to treat "abuse of discretion" as a coherent standard of review. As Bogert observes:

> In addition to the commonly recognized factors used to determine whether there had been an abuse of discretion, a standard of reasonableness has been applied by the courts in judging the exercise of a discretionary power (whether simple or absolute), a standard

> implied from the settlor's intent and the purposes expressed in the trust instrument. With respect to court review of discretionary powers, this standard is consistent with the standard of care and skill of a prudent man and is based upon established fiduciary standards and principles.

GEORGE GLEASON BOGERT ET. AL, TRUSTS & TRUSTEES §560 (rev. 2d ed. 1993)(footnotes omitted). *See also* RESTATEMENT (THIRD) OF TRUSTS § 87, cmt. b (2003) (stating that "[w]hat constitutes an abuse of discretion depends on the terms and purposes of the trust, and particularly on the terms and purposes of the power and any standards or guidance provided for its exercise, as well as on applicable principles of fiduciary duty. Also relevant is the extent of the discretion conferred upon the trustee." (citation omitted)).

What constitutes an abuse of discretion in trust law cannot therefore be reduced to a simple formula, but necessarily involves an evaluation of many factors. The language of the trust instrument is not dispositive. *See id.* §78 cmt. c(2) (explaining that "no matter how broad the provisions of a trust may be in conferring power to engage in self-dealing or other transactions involving a conflict of fiduciary and personal interests, a trustee violates the duty of loyalty to the beneficiaries by acting in bad faith or unfairly").

In determining whether a trustee has abused its discretion, some courts have held explicitly that when a settlor confers discretion on a trustee who

might exercise that discretion in a self-interested fashion, the trustee bears the burden of justifying or explaining self-interested exercises of discretion. See *Estate of Ahrens,* 71 N.Y.S.2d 462, 465 (N.Y. App. Div. 1947). Other courts have not expressed their decisions in burden of proof terms, but have independently weighed the evidence before the trustee, or examined the basis of the trustee's determination with greater care and skepticism.

Courts, therefore, have overturned the discretionary determinations by trustee-beneficiaries on facts that suggest that the trustee's action was inconsistent with the purpose of the trust. Thus, in *Waits v. Hamlin,* 776 P.2d 1003, 1006 (Wash. Ct. App. 1989), the court reversed a trial court determination upholding the trustee-widow's decision to allocate umbrella trust proceeds to her own trust, rather than funding trusts designed for the settlor's first wife and children. The court emphasized that "[t]he intent and purpose of the settlor must be derived from the terms of the instrument, construing all of its provisions together," even though the trust instrument provided that trustee's "decision, in the allocation of funds to the three (3) Trusts, shall be in her sole discretion and final." *See also Carter v. Young,* 137 S.E. 875, 878 (N.C. 1927) (emphasizing that the settlor's conferral of broad discretionary powers on an interested trustee does not relieve courts of the obligation "to effectuate the purpose and intent of a testator"); *Garvey v. Garvey,* 22 N.E. 889, 890 (Mass. 1889) (substituting its discretion for trustee's where trustee refused to make payments to trust beneficiary when the

"purpose and legal effect" of the trust instrument is to give beneficiary the right to payments "if he is thus in need," despite trust language leaving the decision to make payments "entirely to the good judgment of the said trustee").

Of course, sometimes courts sustain an exercise of discretion by a trustee with a conflict of interest. MetLife erroneously suggests that these cases stand for the proposition that "courts do not weigh [the] conflict in reviewing trustees' decisions" (Petr.'s Br. 24) but instead "presume" that a fiduciary with dual loyalties is acting "in accordance with [its] fiduciary obligation" to the trust. (Petr.'s Br. 32). But a careful reading of the cases on which MetLife relies reveals that in each case, the reviewing appellate court engaged in a searching analysis of the evidence to ensure that the trustee had not benefited from his position in a way that undermined the trust's objectives. [2] In no

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[2] Indeed, in most cases, the decision whether a trustee had abused discretion was made only at the conclusion of a trial on the merits. See *Estate of Gilliand*, 140 Cal. Rptr. 795, 797, 801-02 (Cal. Ct. App. 1977)(holding, "after a lengthy trial," that trustees did not abuse discretion because they relied on an independent evaluation by an accounting firm, and declining to remove trustee with a conflict of interest because the trustee's decision furthered the settlor's objectives); *Delaware v. Belin*, 456 So. 2d 1237, 1240--42 (Fla. Dist. Ct. App. 1984) (holding , after "an extended [trial] with conflicting expert testimonies offered by both sides,"that trustees operating pursuant to a settlor-authorized conflict of interest did not abuse discretion because they did not benefit personally and reasonably relied on independent advice); *Estate of Alexander*, 171 S.W.3d 794, 794-95(Mo. Ct. App.

(footnote continued...)

case did the court treat the trustee's conflict as irrelevant or the trustee's decision as presumptively valid.

For example, MetLife relies on *Gregory v. Moose*, 590 S.W.2d 665 (Ark. Ct. App. 1979) for the proposition that courts "presume" that trustees operating under a conflict of interest have acted in good faith and in accordance with fiduciary

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2005)(declining, after a bench trial, to remove trustee operating under a settlor-authorized conflict because trustee reasonably relied on the advice of counsel in making decisions as trustee); *Rosencrans v. Fry*, 95 A.2d 905, 909, 913 (N.J. 1953)(finding, after trial, that trustee's acts furthered the settlor's objectives in creating the trust); *Bank of Nev. v. Speirs*, 603 P.2d 1074, 1076 (Nev. 1979)(finding that trustee did not abuse discretion in failing to purchase additional stock of family corporation for trust because he relied on expert opinion that he should diversify trust assets); *Huntington Nat'l Bank v. Wolfe*, 651 N.E.2d 458, 462 (Ohio Ct. App. 1994) (holding, after trial, that trustees who were officers of family corporation in which trust held stock did not breach their fiduciary duty because the settlor must have intended that the trustee "would take into consideration the interest of the corporation as well as the interest of the beneficiary in making any decisions concerning the family corporations' stock"); *In re Pincus' Estate*, 105 A.2d 82, 86--87 (Pa. 1954) (holding that attorney who operated pursuant to a settlor authorized conflict had not breached his duty to the trust because "[t]here is not a scintilla of evidence in the instant case which could possibly by construed as establishing bad faith"). The other cases MetLife cites for this proposition do not involve trustees operating under a conflict of interest. See *Jarvis v. Boatmen's Nat'l Bank*, 478 S.W. 2d 266 (Mo. 1972); *Rice v. People's Savs. Bank*, 247 P. 1009 (Wash. 1926).

obligations. (Petr.'s Br. 25, 32 & 43). MetLife's reliance on *Gregory* for this point is problematic, for two reasons. First, the trustee's act did not appear to implicate the duty of loyalty. The trustee sold real property held by the trust to disinterested third parties. The only way in which trustee benefited from the sale was by virtue of his status as one of the trust beneficiaries. Trustee could not have benefited disproportionately, either directly or indirectly, from the sale. As a result, the court properly rejected the beneficiary's argument that the trustee was guilty of self-dealing, distinguishing cases where the trustee acquired property in his own name, or "in the name of another to his own benefit, or profiting in an improper way in the handling of trust assets." *Id.* at 670.

Second, the court justified its conclusion that the trustee did not abuse its discretion by emphasizing that the trustee had obtained a thorough and detailed appraisal prior to deciding on the sale price. This evidence, produced during discovery and introduced at trial, established that the trustee had exercised "that degree of skill and care as a man of ordinary prudence would exercise in selling his own property." *Gregory*, 590 S.W.2d at 669. In coming to this conclusion, the court considered and rejected plaintiff's expert testimony that the land was worth more, dismissing it as unpersuasive because the expert formed his opinion more than three years after the sale. Therefore, although the court concludes in the last paragraph of its opinion that a trustee is "presumed" to have acted in good faith, *id.*, the court's analysis belies

that statement. Because the court closely scrutinized the trustee's decision- making process, and took pains to establish that trustee did not improperly benefit from the sale, *Gregory* simply does not establish the proposition that courts defer to the decisions of trustees operating under a conflict of interest.

B. When a Trust Instrument Confers Discretion on a Trustee who is also a Remainder Beneficiary, and Constrains that Discretion by Reference to a Standard, Courts Review the Trustee's Discretion to Ensure Consistency with the Standard.

Although ERISA benefit plans, including the plan at issue in this case, may confer broad discretion on the plan administrator, the administrator's discretion is nonetheless limited by a standard. For example, the administrator may be required to determine whether the employee is "disabled", or whether certain medical fees are reasonable and customary. Even if benefit plans confer discretion on plan administrators to interpret and apply a standard, they do not authorize fiduciaries to ignore those standards in making distribution decisions. Especially when the plan administrator is a residual beneficiary who gains whenever it denies an employee-benefit claim, there is a danger that the plan administrator will improperly consider its own best interests in interpreting the standard.

An identical situation arises in trust law when a settlor names the remainder beneficiary as trustee,

and confers on the trustee discretion to make payments to income beneficiaries in accordance with an ascertainable standard. The less the trustee pays to the income beneficiaries, the more will remain in the trust for distribution to the trustee at the trust's termination. As in the instant case, the trustee may, consciously or unconsciously, interpret the standard unreasonably to increase the amount available to the trustee.

When the trust document sets out a standard to guide the trustee-remainderman in exercising discretion, courts do not defer to the trustee's determination; instead, they carefully scrutinize the trustee's decision to ensure that the decision constitutes a reasonable interpretation and application of that standard. The inference that the settlor has reposed confidence in the trustee must be balanced against the "general recognition that a trustee-beneficiary's conduct is to be closely scrutinized for abuse, including abuse by less than appropriate regard for the duty of impartiality." RESTATEMENT (THIRD) OF TRUSTS §79 cmt. b(1) (2003). Courts have not hesitated to scrutinize carefully the trustee's decision to ensure that the trustee was not motivated by a desire to preserve or increase the trust principal at the income beneficiary's expense.

For example, in *Briggs v. Crowley*, 224 N.E.2d 417, 421 (Mass. 1967), the court held that the probate court had improperly sustained the demurrer of a trustee-remainderman who had discontinued payments to life beneficiaries, despite trust language making "the necessaries and comfort" of the life beneficiaries the "principal

purpose" of the trust. *Id.* at 419, 421-22. The trustee had relied on language in the same paragraph providing that the "trustees, at their discretion, may permanently withhold all money, materials, provisions, benefits, or otherwise of every name and nature from any one or more of the beneficiaries." *Id.* at 419. Despite that language, the court credited the income beneficiaries' contention that "such power and discretion must be exercised by the trustees in conformity with the stated purposes of the trust," and held that the income beneficiaries had adequately alleged that the trustee had "not exercised their discretion in accordance with this standard." *Id.* at 421-22. See also RESTATEMENT (THIRD) OF TRUSTS § 87 cmt. b (2003) ("What constitutes an abuse of discretion depends on the terms and purposes of the trust, and . . . any standards or guidance provided for its exercise, as well as on applicable principles of fiduciary duty"); RESTATEMENT (THIRD) OF TRUSTS § 50(2) (whether a trustee has abused her discretion "depend[s] on the terms of the discretion, including the proper construction of any accompanying standards").

Similarly, in *Pollok v. Phillips*, 411 S.E.2d 242 (W. Va. 1991), the West Virginia Supreme Court reversed the lower court's determination that the trust document's broad grant of discretion limited the court's power to review the decision of a trustee/remainderman. Although the trust document provided that the trustee had "sole" discretion to distribute income to trustee's husband and son, the court focused on language directing that if either the husband or son became

incapacitated, the trustee "may use so much of such income for his ... support, maintenance and welfare as the Trustee determines to be required for those purposes." *Id.* at 243. In holding that the trustee had abused her discretion in failing to make more substantial payments for the son's support after he became incompetent, the court emphasized that even when settlor uses words of discretion, "a trustee is required to act within the bounds of reasonable judgment so as to carry out the settlor's overall intent." *Id.* at 244. The court emphasized that the trustee's conflict of interest was "an additional fact which compels this Court . . . to conclude that it should not be held that the trustee has unbridled discretionary powers." *Id.* at 245.

Further, in *Estate of McCart*, 847 P.2d 184, 186 (Colo. Ct. App. 1992), the court held that when the trust instrument required the trustee-remainderman to provide settlor's spouse with the standard of living to which he was accustomed, even language conferring "sole" and "absolute" discretion did not insulate the trustee's determinations from close judicial scrutiny. The court upheld the trial court's determination to fix both past and future distributions to the spouse, noting that the language of the trust instrument "directs the trustee to maintain, not ascertain, a standard of living calculated upon a *non-variable* factor, settlor's and McCart's years together." *Id.* at 187 (emphasis in original). In other words, because the trustee's discretion was limited by an ascertainable standard, the court was in a particularly strong position to scrutinize the decision of a self-interested trustee.

Other cases take the same approach: when a settlor confers discretion on an interested trustee, but limits that discretion by an ascertainable standard, courts carefully scrutinize the trustee's decisions, evaluating the determinations against the standard set out in the trust instrument. *See, e.g., In re Manahan's Estate*, 125 N.W.2d 135, 138 (Iowa 1963)(overturning determination of trustee-remainderman denying tuition to settlor's grandchildren, concluding that even if trustees had discretion, the discretion "was limited to a determination of whether applicant qualified" under the trust's terms providing for educational assistance); *Garvey v. Garvey*, 22 N.E. 889, 890 (Mass. 1889) (overturning trustee-remaindermen's refusal to make payments to brother, despite illnesses and deaths of family members, because trust instrument required payments in the event of "sickness or other misfortune").

The temptations that faced the trustee-remaindermen in each of these cases are precisely the same temptations that face the ERISA plan administrator in cases where the administrator also funds the plan. In each case, denying benefits preserves assets for the benefit of the remainderman/plan administrator. In this situation, trust law honors the settlor's wishes by permitting the trustee to make the benefits decision, but casts a watchful eye over the decisionmaking process to ensure that the trustee's decision is faithful to the standard set forth in the trust instrument.

Moreover, even when the trust instrument confers absolute discretion on the trustee, rather

than constraining that discretion by a standard, courts carefully scrutinize the trustee's determination. Such cases, of course, are rare, because "[a] fair reading of the whole of most trust instruments will reveal a 'judicially enforceable, external, and ascertainable standard' for the exercise of even broadly expressed fiduciary powers." *Briggs v. Crowley*, 224 N.E.2d 417, 421 (Mass. 1967) (quoting *United States v. Powell*, 307 F.2d 812, 826 (10th Cir. 1962)). And certainly, ERISA benefit plans furnish courts with an ascertainable standard against which to measure the plan administrator's determinations.

Nevertheless, in the few cases in which the settlor provides no express standard against which to measure the self-interested trustee's discretionary determinations, courts have been unwilling to defer to determinations that favor the trustee over other beneficiaries. For example, in *Waits v. Hamlin*, 776 P.2d 1003 (Wash. Ct. App. 1989), the court overturned a widow's decision to allocate moneys to trusts for her own benefit, but not for benefit of settlor's ex-wife, even though the trust instrument provided that the widow's allocation decisions "shall be in her sole discretion and final." And in *Carter v. Young*, 137 S.E. 875 (N.C. 1927), the court overturned a widow's decision not to allocate funds to settlor's grandson even though the trust instrument gave the widow power to allocate "in such proportions and in such manner as she herself may decide." It is critical to note that in *Waits* and *Carter*, the court did more than overturn a decision by a trustee who had been granted sweeping discretion. In each case, the

court overturned a discretionary determination by a trustee whose personal well-being was a prime focus of the trust instrument. A conflicted claim administrator should be accorded even less judicial deference, as the administrator has no comparable right to benefit from an employee-benefit plan.

Indeed, judicial suspicion of the decisions of self-interested trustees is apparent in all areas of trust law. *See Mesler v. Holly,* 318 So. 2d 530, 533 (Fla. Dist. Ct. App. 1975) (indicating that a trustee who is also the life beneficiary of a trust bears the burden of explaining how allegedly excessive distributions made to herself are consistent with the standard set forth in the trust instrument). In some situations, courts have held that an interested trustee has no power to act in his own interest, despite the language of the trust instrument. For instance, a number of cases have held that a trustee who is also a life beneficiary may not exercise discretion in favor of himself without prior judicial authorization. *See, e.g., Rogers v. Rogers,* 18 N.E. 636, 638 (N.Y. 1888); *Armington v. Meyer,* 236 A.2d 450 (R.I. 1967).

The concern reflected in these cases is the same concern that mandates closer scrutiny of the decisions of the trustee-remainderman than of the decisions made by a disinterested trustee: self-interest is a powerful force that requires application of judicial checks and balances, whatever the language of the trust instrument. *Compare* RESTATEMENT (THIRD) OF TRUSTS §50 cmt b (2003), illus. 1, *with id.*, illus. 2 (noting that courts will review a disinterested trustee's exercise of discretion only for abuse, but will carefully

scrutinize for reasonableness the exercise of discretion by an interested trustee).

C. Cases Involving Trusts That Hold Stock in Family Businesses are not Analogous to the ERISA Context, and do not Establish that Courts Defer to Discretionary Decisions made by a Trustee with a Conflict of Interest.

Many of the cases on which Met Life relies for the proposition that courts apply a deferential standard of review involve trustees who are also officers and directors of family businesses in which the trust holds stock. In these cases, the trust settlor does not intend for the trustee to have undivided loyalty to the trust beneficiaries. Instead, the settlor has dual objectives -- she wants to benefit both the trust beneficiaries and the family business – and she expects the trustee, who is also a fiduciary for the family business, to balance those objectives.[3]

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[3] *See Huntington Nat'l Bank v. Wolfe*, 651 N.E.2d 458, 467-68 (Ohio Ct. App. 1994) (holding, after trial, that trustees who were officers of family corporation in which trust held stock did not breach their fiduciary duty because the settlor must have intended that the trustee "would take into consideration the interest of the corporation as well as the interest of the beneficiary in making any decisions concerning the family corporations' stock"); *Rosencrans v. Fry*, 95 A.2d 905, 909, 913 (N.J. 1953); *Bank of Nev. v. Speirs*, 603 P.2d 1074, 1076 (Nev. 1979); *Estate of Halas*, 568 N.E.2d 170 (Ill. App. Ct. 1991); *cf. Goldman v. Rubin*, 441 A.2d 713 (Md. 1982)(remanding

(footnote continued...)

For at least two reasons, these cases do not support deferential review of ERISA benefit denials. First, ERISA does not allow benefit providers to take their own self-interest into account when making benefit determinations. Second, in these family business cases, courts have not deferred to trustee decisions concerning trust property. They have scrutinized trustee determinations through a broader lens than usual, because the trust instrument does not contemplate that the trustee will display undivided loyalty to the trust beneficiaries. But it is erroneous to conclude, as MetLife does, that courts presume that trustee decisions are made in good faith; instead, courts scrutinize those decisions to ensure that they constitute a good faith attempt to effectuate settlor's intent.[4]

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for a determination of whether trustee who was an officer of family corporation had abused his discretion).

[4] Consider *Estate of Halas*, 568 N.E.2d 170 (Ill. App. Ct. 1991), on which MetLife relies. (Petr.'s Br. 43) In that case, the court partially reversed the trial court's determination that George Halas, trustee of a trust created by his son and funded by the son's 20% interest in the Chicago Bears, had breached his fiduciary duties. Halas was the majority shareholder of the Bears, and he reorganized the club after his son's death. The trust beneficiaries claimed that the trustee's reorganization plan failed to maximize the value of the trust, but the appellate court sustained the trustee's action. In doing so, the court painstakingly reviewed the evidence, including expert testimony, that both parties had presented at trial. It also emphasized the trust instrument's broad grant of discretion to the trustee, which included the

(footnote continued...)

III. ERISA DOES NOT ENTITLE PLAN SPONSORS, ESPECIALLY THOSE WHO FACE A CONFLICT OF INTEREST, TO ELIMINATE MEANINGFUL JUDICIAL REVIEW OF BREACH OF FIDUCIARY DUTY CLAIMS BY INSERTING BROAD CONTRACT LANGUAGE INTO PLAN DOCUMENTS.

In looking to the common law of trusts as a foundation for the responsibilities of ERISA plan fiduciaries, this Court emphasized that "ERISA was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans.'" *Firestone,* 489 U.S. at 113 (1989). The Court noted that "[a]dopting Firestone's reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* at 113-14. That is, before ERISA, an employee had a contract claim against

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power to participate in "reorganizations" of the club "*as though no . . . conflict of interest existed.*" *Id.* at 173 (emphasis in original). The appellate court did not hold that the trial court erred in failing to defer to the trustee's exercise of discretion. Rather, it reversed the lower court because its decision frustrated the settlor's purpose in creating the trust and naming his father as trustee. Because the trustee conferred broad self-dealing powers on Halas to ensure the well-being of the ball club, as well as to take adequate care of the trust beneficiaries, and the trustee's entire family, Halas' reorganization plan was not a breach of trust. *Id.* at 178--79.

its employer or the employer's insurance company if benefits were wrongfully denied. *Id.* at 112-113. Pre-ERISA, however, contract principles did not permit a court to defer to determinations made by the drafting party to a contract of adhesion; instead, the court would construe the contract in accordance with its terms.

At its core, ERISA is a regulatory statute. As the preceding section demonstrates, the common law of trusts constrains the discretion of self-interested trustees, regardless of the language of the trust instrument, because courts understand that trust settlors do not generally anticipate that the chosen trustee will exalt his own interests over those of the beneficiaries. The case for constraining a fiduciary's discretion is even stronger when the fiduciary relationship is defined by a regulatory statute such as ERISA and not merely by private contract. As Professor Langbein has observed, "[w]hen a legislature absorbs a private-law regime such as trust law for regulatory purposes, as did Congress in ERISA, the regulatory purposes should be understood to dominate, and, where necessary, to alter the application of the borrowed principles." John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1336 (2007).

Congress, in enacting ERISA, borrowed the default rules of trust law but did not confer on sponsors the same rights to modify those default rules that would typically be available to the settlor of a private express trust. For instance, trust law's duty of loyalty is a default rule, subject to

modification (though not complete abrogation) by the terms of the trust instrument. By contrast, ERISA's duty of loyalty requires an ERISA fiduciary to interpret and apply plan terms "solely in the interest of the participants and beneficiaries and ... for the exclusive purpose of ...providing benefits to participants and their beneficiaries...." 29 U.S.C. § 1104(a)(1)(A)(2000). The statute makes no provision for contract modification of that duty. *See also* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1330 (2007).

Similarly, despite the importance of the duty of care, trust law gives settlors considerable power to adjust the level of care a trustee must take in evaluating the claims of beneficiaries, and even permits settlors to exculpate trustees from all liability for breaches of the duty of care. ERISA, by contrast, requires a plan's procedures to ensure "full and fair review by the appropriate named fiduciary" of any benefits denial (29 U.S.C. § 1133(2) (2000)) and declares exculpatory clauses "void as against public policy." (§1110(a)). The statutory requirement of "full and fair review" would be rendered meaningless if a self-interested fiduciary could escape careful judicial scrutiny of its determinations simply by conferring on its administrators broad discretion in evaluating claims.

Indeed, the very word "fiduciary"—used in the statute to define the duties of plan administrators and others—reflects Congressional concern with assuring that plan administrators remain faithful

to the interests of plan participants and beneficiaries. *Firestone*, 489 U.S. at 110 ("ERISA's legislative history confirms that the Act's fiduciary responsibility provisions, 29 U.S.C. §§1101-1114, 'codif[y] and mak[e] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the law of trusts.' H.R. Rep. No. 93-533, p.11 (1973), U.S. Code Cong. & Admin. News 1974, pp.4639, 4649.") [5]

Congress had good reasons to model ERISA's fiduciary obligations on trust law, and equally good reasons to limit the power of plan sponsors to adjust those obligations. When a settlor creates a private express trust, the settlor is selecting a mechanism for management and disposition of his own money, making it appropriate for courts to defer to his wishes. By contrast, an ERISA plan does not result from the beneficence of the plan sponsor; the plan constitutes part of the employee's compensation package. From the employee's standpoint, ERISA benefit plans "are characteristic contracts of adhesion, offered on a take-the-plan-or-leave-the-job basis." Langbein, *supra* at 1323. Because the plan's terms reflect the preferences of only one of the parties whose interests are at stake, principles of contractual autonomy do not justify the same judicial deference to the language of the plan. *See Burroughs v. Bellsouth Telecom-*

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[5] *See also* John H. Langbein, *What ERISA Means By "Equitable": The Supreme Court's Trail of Error in* Russell, Mertens *and* Great-West, 103 COLUM. L. REV. 1317 (2003).

munications, Inc., 446 F. Supp. 2d 1294, 1298 (N.D. Ala. 2006)(stating that "Although, in theory, the plan document is thought of as a contract between the employer (the plan sponsor) and the employee (the plan participant or beneficiary), it never is truly the product of arms-length negotiation.... The employee plays no part in fashioning the coverage or the claims procedure").

Although ERISA limits the power of plan sponsors to contract out of trust law's default rules even when the plan administrator is not in a position of conflict of interest, MetLife in this case does face a conflict of interest. To the extent ERISA's embrace of trust principles was designed to protect the expectations of plan beneficiaries whose employment decisions are based in part on their employee benefit plans, the statutory purpose is not advanced by permitting a plan sponsor (1) to confer decision-making power on an administrator who benefits from each claim denial, and (2) to insulate that administrator from meaningful judicial review of those denials. Yet that is precisely what MetLife has asked this Court to sanction.

Respectfully submitted,

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